STATE TITLE V BLOCK GRANT NARRATIVE
STATE: WA
APPLICATION YEAR: 2006

I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

To obtain a copy of the Assurances and Certifications, contact:

Jan Fleming, Director
Washington State Department of Health
Office of Maternal and Child Health
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Olympia, WA 98504-7835

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D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

Input for the MCH Block Grant application involved working with multiple existing stakeholder groups, including families and family organizations. These groups are actively engaged, on a regular basis, with specific MCH sections and populations, and sometimes more than one population group. Stakeholders represent communities, healthcare professionals, universities, state agencies, local health jurisdictions, and other organizations. They are knowledgeable and articulate about MCH needs and emerging issues.

Involving stakeholders in our MCH Block Grant Application and Five Year Needs Assessment Process allows for greater appreciation and understanding of work at all levels and for mutual learning, problem solving, and growth. Stakeholders provided input throughout development of our Five Year Needs Assessment. Progress was shared regularly as the OMCH Director, managers, and staff met with stakeholders. Presentations were made to multiple groups as we began to frame the assessment and identify potential MCH priorities. Feedback from these presentations was overwhelmingly positive -- the framework and language in the draft priorities resonated with all groups and they commented about how beneficial it would be for them as well as for state level work.

Stakeholders will continue to be included in shaping the final MCH priorities through the existing communication channels. In this way, the priorities and related performance measures will be relevant for al of Washington State.

II. NEEDS ASSESSMENT

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

Washington State encompasses over 66,000 square miles of the northwest corner of the United States. It is bordered north and south by British Colombia and Oregon, east and west by Idaho and the Pacific Ocean. The Cascade Mountains divide the state into distinct climatic areas. Western Washington, sandwiched between the Pacific Ocean and the Cascades, has an abundance of rain. The geographically larger area east (and in the rain shadow) of the Cascades is much dryer.

While the average population density in the state in 2000 was 88.5 persons per square mile, and similar to the national rate, nearly 80 percent of Washington's population is concentrated west of the Cascades. The three most populous counties, King, Pierce, and Snohomish are located on and prosper from Puget Sound. Another western county, Clark, gains economically from proximity to Portland, Oregon, while the city of Spokane and Spokane county in eastern Washington, are near enough to benefit from Coeur d'Alene, Idaho.

Geography, climate and economic resources influence Washington's population distribution. Population density ranges from 817 persons per square mile in King County to 3 persons per square mile in Garfield and Ferry counties.(1) Washington has 39 counties, each with its own local government. These counties form 35 independent Local Health Jurisdictions (LHJs), funded with varying amounts of federal, state, and local dollars.

Population Density(2)

(See attached map)

Economy

Washington State continues to struggle with an economic slowdown resulting from a combination of factors. To the aftermath of the burst dot.com bubble and the decline of airframe demand, resulting in part from the events of September 11, 2001, has recently been added this nation's first case of "Mad Cow Disease," bovine spongiform encephalopathy (BSE), in Mabton, Washington. Prior to the BSE incident, in November 2003, the State's seasonally adjusted unemployment rate was 6.8 percent. Washington's unemployment rate still remains one of the highest in the nation, ranked as 38th. The state unemployment rate was 5.5% (as of April 2005) compared to 5.4% nationally (February 2005). (3)

Several years of economic doldrums, combined with spending constraints and spending limits from voter-approved initiatives, have produced a continuing budget crisis for Washington. In the past, state revenue "surpluses" have been available to backfill revenue shortfalls faced by local governments. Continuing budget problems greatly reduce the state's capacity to subsidize local government revenue shortfalls, with the result that many local programs are struggling financially.

Economic hard times also increase the need for public health services, so the current decrease in funding is having a major impact on local public health. As the economic and state fiscal crisis continues, future reductions in local public health are expected. Local Health Jurisdictions (LHJs) are currently being forced to reduce staff and programs.

Population

Washington's population continues to grow. The 2000 Census indicated the state's population was 5,894,121, an increase of 21.1 percent since the 1990 Census.(4) The Washington Office of Financial Management's (OFM) preliminary intercensal population estimate for the State in 2004 was 6,167,800.(5)

In the early 1990s, Washington's population grew by over 2 percent per year, nearly twice the national rate. In 2000, the state ranked seventh in the country in numerical population growth and tenth in percentage population growth since 1990, according to the 2000 Census.(6) However, from 1995-2000 growth slowed to an average of 1.3 percent per year and since 2000, has averaged 1.1% per year. Since 1995, natural population increase (births minus deaths) has remained fairly constant, while net migration (people moving into the state versus people moving out) has decreased from 68.3 in 1995 to an estimated 23.1 in 2003.(7) This decrease was most likely due to the strong national economy of 1990s and the increasingly poor economy in Washington in the past few years, resulting in fewer people looking for employment opportunities in Washington.(8)

Race/Ethnicity in Washington State

The majority of Washington's population identifies itself as White and non-Hispanic. In the 2000 Census, 81.8 percent of Washington's population reported its race as White, 5.5 percent Asian, 3.2 percent Black, 1.6 percent American Indian or Alaskan Native, 0.4 percent Native Hawaiian and other Pacific Islander, and 3.9 percent Other. Individuals who reported two or more races accounted for 3.6 percent. Finally, 7.5 percent of the population reported Hispanic or Latino ethnicity.(9)

Although the majority of Washington's population remains White and non-Hispanic, the state's other race and ethnic minority populations increased rapidly in the last decade. Together, non-Whites and Hispanics in Washington increased from 13.2 percent of the overall population in 1990 to 21 percent (1,241,631) of the population in 2000. The State population of Asian and Pacific Islanders increased 78 percent; Blacks 35 percent; and American Indians, Alaskan Natives, and Aleuts 29 percent.

The Hispanic population in Washington State has more than doubled since the 1990 Census, from 214,570 in 1990, to 441,509 in 2000. Counties with large proportions of Hispanics tend to be located in rural areas of Eastern and Central Washington. In Adams County, the Hispanic population rose from 32.8 percent in 1990 to 47.1 percent in 2000; Franklin County saw an increase from 30.2 percent to 46.7 percent; and Yakima County saw an increase from 23.9 percent to 35.9 percent While Hispanics make up a large proportion of the population in these counties, the largest number of Hispanics live in King, Pierce, and Snohomish counties. The majority (74.7 percent) of Hispanics in Washington are from Mexico, 20.6 percent are from "other countries" (Central and South America), 3.7 percent from Puerto Rico, and 1.0 percent from Cuba. (10) In 2000, there were approximately 289,000 migrant and seasonal farm workers and dependents living in Washington, who were primarily Hispanic. Migrant and seasonal farm workers are more likely to have low family incomes, face language barriers, and have limited transportation options. Most rely on Community and Migrant Health Centers (CMHC) for their health care.

Blacks and Asian/Pacific Islanders are predominantly located in urban areas west of the Cascades. Approximately 50 percent of each population resides in King County alone. There are also 29 federally recognized American Indian tribes throughout Washington with varying populations and land areas, and two more tribes seeking federal recognition.

Languages

According to the 2000 Census, approximately 15 percent, or 168,000, of Washington's children age 5-17 speak a language other than English at home. Of these children, 43 percent speak Spanish, 29 percent speak Asian and Pacific Islander languages, 26 percent speak other Indo-European languages, and 4 percent speak other languages. A similar figure of 14 percent, or 512,000, of the adult population age 18-64 does not speak English at home. Of those who do not speak English at home, 88 percent of the children and 75 percent of the adults speak English "very well" or "well." Twelve percent of the children and 25 percent of the adults, speak English "not well" or "not at all."(11)

Approximately 40,700 Spanish-speaking students were enrolled in the English as a Second Language program in Washington State for the 1999-2000 school year. Other languages with high enrollments were

Russian (5,500), Vietnamese (3,200), Ukrainian (2,900), Korean (1,800), Cambodian (1,400), and Tagalog (1,000). 11

Age

In 2003, there were 80,482 resident births in Washington State. The Census 2000 population counts show that almost 22 percent, or 1.29 million of the estimated 5.9 million people in Washington in 2000, were women of reproductive age (15-44 years). Nearly 29 percent, or 1.68 million, were children 19 and younger. Within both of these groups are over 125,000 women age 15 to17. Adolescent pregnancy rates (ages 15-17) have declined in Washington from 57.9 per 1,000 women in 1990 to 28.8 per 1,000 women in 2003.(12) A State forecast predicts that over the next 30 years, as the children of baby boomers reach adulthood, the number of women of reproductive age will increase substantially. The school age population (5-17 years) is expected to remain stable through 2010 and then gradually increase. In 2004, there were an estimated 1,120,913 children and adolescents aged 5 to 17.(13)

Urban/Rural

Seventy-two percent of population growth over the past decade has occurred in the western portion of the state, where the majority of the population lives. While there are many rural areas in Western Washington, the most rural counties are located in Eastern Washington. Rural county residents tend to have lower median household incomes, higher poverty rates, and higher unemployment rates. A recent review of health status indicators found some differences between the health status of rural and urban residents, though it is difficult to assess specifically whether the decreased health status is linked to rural location, isolation, or decreased access to care.(14)

Poverty and Health Insurance

According to the 2004 Washington State Population Survey, an estimated 24.5 percent of Washington households had a family income below the 200 percent Federal Poverty Level, compared to 18.8 percent in 2002. An estimated 9.9 percent of households had an income below the 100 percent of FPL.(15) Data on households with children is not yet available, but according to the 2002 Washington State Population Survey, an estimated 35 percent (approximately 574,000) of children in Washington were living below 200 percent of the Federal Poverty Level (FPL, $18,392 for a family of four in 2002), compared to 33.4% in 2000. An estimated 18 percent (about 284,000) of the children were living below 100 percent of FPL and 11 percent (about 180,000) were living at or below 50 percent of FPL.(16)

Findings from the 2004 Washington State Population Survey indicate the percent of Washington residents without health insurance is also increasing. Among the general population, 8.4% were uninsured in 2002 compared to 9.8% in 2004, a 17% increase. The percent of uninsured children increased approximately 33% from 4.5% in 2002 to 6.0% in 2004, amounting to over 98,000 uninsured children in Washington.(17)

The Washington State Medical Assistance Administration (MAA) provides health care services to low income people in Washington, primarily through the federal/state Medicaid partnership. In 2003, Medicaid covered pregnant women up to 185 percent of the FPL and paid for prenatal care and deliveries for approximately 46 percent of state births.(18) The "Take Charge" program at MAA provides family planning for men and women with incomes at or below 200 percent FPL. The State Children's Health Insurance Program (SCHIP) provides health coverage for children of families with incomes between 200% and 250% FPL.

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(1) Washington State Office of Financial Management, US Census 2000 Maps

(2) Washington State Office of Financial Management, US Census 2000 Maps

(3) US Department of Labor, Bureau of Labor Statistics, April 2005

(4) Washington State Office of Financial Management, Population Forecasting Division, Census 2000 results show Washington's population increased by over 1 million during the 1990s, 12/28/2000.

(5) Washington State Office of Financial Management, 2004 State Estimates.

(6) US Census Bureau, Census 2000 Redistricting Data (P.L. 94-171) Summary File and 1990 Census, 4/02/2001.

(7) Washington State Data Book 2003, Components of Population Change Table.

(8) Washington State Office of Financial Management, Population Forecasting Division, Washington's Population Growth Continues to Slow, 6/30/2000.

(9) US Census Bureau, Census 2000, Table DP-1, Profile of General Demographic Characteristics: 2000.

(10) 1990 and 2000 Census, Office of Financial Management.

(11) US Census Bureau, Census 2000 Supplementary Survey Summary Tables, Table PO35, Age by Language Spoken at Home by Ability to Speak English for the Population 5 Years and Over.

(12) Washington State, Pregnancy and Induced Abortion Statistics 2003, Center for Health Statistics, March 2005.

(13) Washington State Office of Financial Management, Forecast of the State Population by Age and Sex, 1990 to 2030, November 2004.

(14) Schueler V, Stuart B. "Recent research and data on rual health in Washington State", Olympia, Washington, October 2000.

(15) Office of Financial Management, 2004 Washington State Population Survey, December 2004.

(16) Data provided by Washington's Office of Financial Management.

(17) Gardner, Erica. "The Uninsured Population in Washington State", 2004 Washington State Population Survey Research Brief No. 31, Washington State Office of Financial Management, March 2005.

(18) Cawthon, Laurie. "Characteristics of Washington State Medicaid Women Who Gave Birth", DSHS Research and Data Analysis, 2/23/2005.

B. AGENCY CAPACITY

The Office of Maternal and Child Health (OMCH) works to protect and improve the health of people in Washington State with a focus on women, infants, children, adolescents, and families. MCH programs work in close partnership with state and local agencies and consumers to promote effective health policies and quality systems of care. MCH data is collected, analyzed, and shared with other agencies and organizations to assure sound decision-making around health care policies and practices. MCH program activities emphasize infrastructure-building and population-based activities through preventive health information and education messages to the public and to health providers, early identification of health issues, referral and linkage to services, and coordination of services. Programs contract with 35 local health jurisdictions, community-based organizations, universities and hospitals, direct service providers, family organizations, and other agencies and organizations to address MCH priorities and state and national performance

measures.

The Office of Maternal and Child Health is responsible for administering the Title V Block Grant, the CDC Immunization Grant, and a variety of other federal grants pertinent to MCH priorities and performance measures.

State statutes relevant to Title V program authority and how they impact the Title V program remain the same as those outlined in pages 8-11 of the 1996 Block Grant Application.

Capacity for better understanding of cultural competence as an office and for staff has improved over the years due to continued participation in the division level Multi-Cultural workgroup. A number of staff assumed leadership positions in this group and all staff participate in initial and ongoing training.

The Office of Maternal Child Health addresses health disparities through the MCH Health Disparities Workgroup. This group was created several years ago to specifically address health disparities in the MCH population. Each OMCH section develops goals and objectives to reduce health disparities for the populations they serve. We are in the process of learning about and incorporating Culturally and Linguistically Appropriate Services (CLAS) created by the Office of Minority Health.

The Office of MCH is comprised of seven separate sections, each with a specific focus. Three sections in OMCH target the major Title V populations: Maternal and Infant Health, Child and Adolescent Health, and Children with Special Health Care Needs. The other sections focus on issues that encompass the entire MCH population: Genetics, CHILD Profile, Immunizations, and MCH Assessment. Following is a brief description of the basic role of each OMCH section. Funding is through a combination of sources including Title V, State General Funds, the CDC, and Title XIX.

Maternal and Infant Health (MIH)
MIH, comprised of 11.20 full time equivalents (FTEs), works to improve birth outcomes by promoting quality health and support services for pregnant and post-partum women and their infants. This work is accomplished through training, education, assessment, and intervention and with a system of regional perinatal care services that include the availability of quality tertiary care for high-risk women and newborns. Other services are provided through a collaborative network of state, Local Health Jurisdictions (LHJs), and non-profit providers. This network provides confidential pregnancy testing (limited) and referral, maternity support services, child development, and parenting information and education.

Child and Adolescent Health (CAH)
CAH, with 15 FTEs, works to promote and protect the health and well-being of children, adolescents, and their families in the context of their communities through assessing child and adolescent health status, developing strategies to improve health status, and assuring preventive health services. Through its programs, CAH promotes the use of national guidelines for well child and adolescent screening and referral, family support and leadership, teen pregnancy prevention, youth development, population-based oral health programs, promotion of social emotional well-being and mental health, and child care health consultation.

CHILD Profile (CP)
This section includes 5.5 FTEs. The work is twofold: an Immunization Registry and Health Promotion System for parents of young children. These two components assure that parents have information to assist and support them in making health care decisions about their children, providers have access to a repository of data to make immunization decisions, and public health has the information needed to protect the public from vaccine preventable diseases. DOH contracts with Public Health-Seattle King County and the University of Washington (UW) staff for primary CHILD Profile operations. This program will merge with Immunization Program in the next few months.

Children with Special Health Care Needs (CSHCN)
The CSHCN Program has a total of 8.0 FTEs. The program promotes integrated systems of care that assure children with special health care needs and their families have the opportunity to achieve the healthiest life possible and develop to their fullest potential. CSHCN staff provide leadership in addressing

health system issues that impact this population; work with families and other leaders to influence priority setting, planning and policy development; and support community efforts in assessing the health and well-being of children with special health care needs and their families. This work is carried out through partnerships with other state-level agencies, contracted relationships with LHJs, private and non-profit agencies, the University of Washington, Children's Hospital and Regional Medical Center, other tertiary care centers, and family organizations. These contracts and partnerships significantly extend CSHCN program capacity in the areas of policy development, assessment, provider education, and family leadership development.

Genetic Services
Genetic Services, with 7.0 FTEs, is focused on assuring high quality comprehensive genetic services throughout the state. This section also includes activities aimed at surveillance and intervention for secondary conditions affecting people with disabilities; FAS prevention; genetics education; technical assistance to the newborn screening program; and early promotion of hearing loss detection, diagnosis, and intervention.

Immunization Program (IP)
This program, with 20.0 FTEs and funding from the CDC and state, is committed to preventing the occurrence and transmission of childhood, adolescent, and adult vaccine-preventable diseases. The program provides leadership for an integrated and comprehensive immunization delivery system and universal vaccine access for all children less than 19 years of age. The IP expands public awareness of the need for immunizations throughout the life span and promotes community education, participation, and partnerships. The program has significant partnerships within the department including the Bioterrorism Prevention program, Communicable Disease and Epidemiology, CHILD Profile, Infectious Disease. Additionally, this program has established partnerships with the Washington Chapter of the American Academy of Pediatrics, the Washington Chapter of the Academy of Family Practice, a Vaccine Advisory Committee of expert physicians, a statewide coalition, and all local health jurisdictions.

MCH Assessment (MCHAS)
This section, with 12.15 FTEs, provides data, analysis, research, surveillance, and consultative support and management of all assessment activities within OMCH. Specific activities include leading the Five Year Needs Assessment process, performance measures and health indicator status reporting, administration and analysis of Pregnancy Risk Assessment Monitoring System data and development of data reports, collection, and analysis of data from child death reviews, cluster investigations, birth defects surveillance, and implementation of State Systems Development Initiative activities. MCHAS also designs and implements surveys and responds to data requests from the OMCH, other programs within the Department of Health, local health jurisdictions, and other external stakeholders.

MCH Administration
This section has a total of 4.8 FTEs and provides administrative support to the sections of the Office of Maternal and Child Health by way of policy and fiscal development and oversight.

C. ORGANIZATIONAL STRUCTURE

The Department of Health is located within the Executive Branch of state government, with the Secretary of Health reporting directly to the Governor. DOH includes five major divisions, one of which is Community and Family Health. The Office of Maternal and Child Health is one of three offices within this division. In Washington State, the Children with Special Health Care Needs Program is part of the OMCH.

The Department, through the Office of the Assistant Secretary for Community and Family Health and the Office of Maternal and Child Health, is "responsible for the administration (or supervision of the administration) of programs carried out with allotments under Title V" (Section 509(b)). All programs funded by the Federal-State Block Grant partnership are included under this administration (Form 2, Line 8)."

For a Department of Health organization chart, go to the following internet link:
http://www.doh.wa.gov/Org/org.htm

For a Division of Community and Family Health organization chart, go to the following internet link: http://www.doh.wa.gov/cfh/CFHOrgChart.htm

For an Office of Maternal and Child Health organization chart, see the attached file: IIIC_OrganizationalStructure.pdf

D. OTHER MCH CAPACITY

The Office of Maternal and Child Health has a total of 83.65 FTEs with staff in a variety of specialty areas including: epidemiology, public health administration, public health nursing, social work, oral health, children with special health care needs, obstetrics, perinatal care, adolescents, early childhood, health education, nutrition, genetics, immunizations, and psychology. OMCH also employs a parent of a child with special health care needs as a full-time family consultant for the CSHCN program. This individual works with staff on all CSHCN issues and plays an instrumental role in facilitating family consultation and participation within OMCH and at the local, regional, and state level.

The majority of staff are located in Olympia, Washington. The Genetics Services section is located in Kent, Washington near Seattle.

Following are brief biographical sketches of DOH senior management and managers within OMCH:

Mary Selecky has been the Secretary of Health for six years and was recently reappointed by Governor Christine Gregoire. She is a political science and history graduate of the University of Pennsylvania and past president of the Association of State and Territorial Health Officers (ASTHO). Prior to her appointment as Secretary of Health, Mary worked for 20 years as the Administrator of the North East Tri-County Health District in eastern Washington.

Dr. Maxine Hayes serves as the Health Officer for DOH. Prior to this, she was the Assistant Secretary of Community and Family Health, the Title V Director, and president of the Association of Maternal and Child Health Programs. Dr. Hayes is Associate Professor of Pediatrics at the University of Washington, School of Medicine and is on the MCH faculty at the university's School of Public Health and Community Medicine.

Patty L. Hayes is the Assistant Secretary for the Division of Community and Family Health. Prior to this, she was Director of the DOH Office of Policy, Legislative and Constituent Relations, Assistant Professor of the Master's Program in Leadership and Public Policy at St. Martin's College, and Executive Director of the Nursing Care Quality Assurance Commission. In 2002, Patty L. Hayes was inducted to the Nursing Hall of Fame for Washington, sponsored by the Washington State Nurses Association.

Rick McNeely is the chief administrator for the Division of Community and Family Health. He has been with the Department of Health in a budget leadership role for over ten years. Rick received his bachelor's degree in accounting from Tuskegee University.

Jan Fleming is the director of the Office of Maternal and Child Health. She is a registered nurse with a master of nursing degree and clinical specialty in children with special health care needs from the University of Washington. She has been with OMCH since 1990 and previously worked with children with special health care needs and their families in a university-affiliated program, in schools, public health departments, and as a Clinical Nurse Specialist in an early intervention program.

Kathy Chapman, manager of the Maternal and Infant Health section, has a master's degree in maternal and child health nursing from the University of Washington. She was previously the manager of the Children with Special Health Care Needs Section and also supervised the MCH Assessment Section for several years. Kathy has worked 20 years in state and local public health programs focusing on maternal and child health issues.

Debra Lochner Doyle, manager of the Genetic Services section, has a bachelor of science degree in genetics from the University of Washington and a master of science degree in human genetics and genetic counseling from Sarah Lawrence College in New York. She is board certified by the American Board of Medical Genetics and the American Board of Genetic Counseling. She is also the past president of the National Society of Genetic Counselors and a founding member of the Coalition of State Genetic Coordinators.

Maria Nardella is the manager of the Children with Special Health Care Needs Program. Maria has 20 years experience in state CSHCN programs. She is a Registered Dietitian with a bachelor of science degree in nutrition from Cornell University and a master of arts in nutrition and mental retardation from the University of Washington, including clinical training at the university-affiliated program.

Nancy Reid, manager of the Child and Adolescent Health section, has a master of social work degree from the University of Washington and a bachelor of arts degree from the University of Maryland. Prior to coming to OMCH, Nancy worked for 21 years managing statewide sexual assault, domestic violence, and alcohol and substance abuse programs at the Department of Social and Health Services.

Janna Bardi, manager of the Immunization Program, has a master of public health degree in behavioral science and health education from the University of California, Los Angeles. She was previously the manager of the CHILD Profile Section and has experience in program analysis, policy development, systems development, inter- and intra-agency collaboration, and program evaluation. Janna is a 2003 scholar of the Northwest Public Health Leadership Institute.

Riley Peters, manager of the MCH Assessment section, has a PhD in epidemiology from the University of Washington. He also holds a master's in public administration with an emphasis in health administration from the University of Southern California. He has worked in local and state public health for over 20 years.

E. STATE AGENCY COORDINATION

The following provides a brief description of the collaborative relationships the Office of Maternal and Child Health has developed within the office and DOH, and with MAA (Title XIX), other state agencies, and other organizations. The outcomes of many of these collaborations are described in more detail in other portions of this application.

Washington State Board of Health (SBOH): The SBOH is an independent 10-member board appointed by the Governor. The Secretary of Health is a required member. The OMCH works with the SBOH on children's health issues, including rules for newborn screening; prenatal screening; HIV testing of pregnant women; immunization requirements for school and child care attendance; and hearing, vision, and scoliosis screening in schools. The OMCH also works with the SBOH on a legislatively mandated study on genetics.

1. OMCH Relationships with Other Offices Within the Washington State DOH

Assessment Operations Group (AOG): MCHAS and other DOH epidemiology staff participate in a monthly department-wide AOG to set standards for all assessment functions within DOH, coordinate assessment activities, and facilitate communication across the department. The MCH Assessment section manager sits on the AOG. This collaboration has resulted in improved coordination with the Center for Health Statistics and LHJ assessment staff.

Community and Rural Health: OMCH works with the DOH Office of Community and Rural Health on several issues, such as identifying unmet needs, women's health, obstetrical access, immunization rates, and domestic violence.

The DOH Family Violence Prevention Workgroup: This agency workgroup is comprised of representatives from OMCH, Injury Prevention Program, Emergency Medical Services (EMS), and Family Planning. They meet monthly to coordinate activities, and plan, evaluate, and secure resources to decrease family violence.

Environmental Health: CHILD Profile is working with Environmental Health to determine priority environmental health risks for children and develop educational materials to increase parental knowledge of how they can protect their children from several environmental toxins. The Office of Environmental Health Assessments and CHILD Profile developed the "Fish Facts for Good Health" brochure which explains the risks of ingesting high levels of mercury and how to limit exposure to mercury.

Office of Epidemiology: The childhood Lead Poisoning Prevention Program and CHILD Profile developed the "Lead and Your Kids" brochures, which is being distributed to parents of children 6 months of age. This brochure discusses how to reduce exposure to lead in and outside the home.

Office of Infectious Disease and Reproductive Health (IDRH): OMCH collaborates with the HIV/AIDS and Family Planning and Reproductive Health Programs (FPRH) in IDRH and other contractors through the MCH/HIV Workgroup. The focus of this workgroup is to develop effective policies and programs for HIV/AIDS prevention and care in the MCH population and increase the number of medical providers who recommend HIV testing for all pregnant women. OMCH also works with FPRH to reduce unintended pregnancy and promote the Take Charge Program.

Injury Prevention: OMCH collaborates with the Injury Prevention Program and partially funds data collection and reporting of intentional and unintentional injuries, youth suicide, and family violence. CHILD Profile partners with the Injury Prevention Program to provide product safety messages to Washington State parents with children between birth to six years of age.

Oral Health: The OMCH Oral Health Program collaborates with the DOH Environmental Health Division, Epidemiology Program, Office of Health Promotion, Office of Community and Rural Health, and HIV/AIDS Program to enhance preventive oral health care and address unmet needs. OMCH also works with the Office of Drinking Water on fluoridation. The Maternity Support Services Program (MSS) educates providers regarding pregnancy and oral health and makes educational materials available to women on Medicaid.

Healthy Child Care Washington (HCCW): HCCW works with the Division of Environmental Health, the Immunization Program, CHILD Profile, Bright Futures, Parent Education/Family Support, and Child Death Review (CDR) teams related to SIDS prevention and oral health.

Tobacco Control and Prevention Program (TCPP): OMCH continues to work closely with TCPP on maternal and infant health issues. The TCPP program funded development and training for the MSS tobacco cessation project, and worked with OMCH staff to successfully advocate for Medicaid coverage of smoking cessation treatment for pregnant women. The TCPP contributes funds to the Healthy Mothers Healthy Babies (HMHB) toll-free line, which now asks callers about tobacco use and includes Tobacco Quit Line information in their prenatal and child health education packets. The TCPP is also involved in developing the Healthy Youth Survey (HYS) and provides major funding for this survey. The TCPP works closely with Pregnancy Risk Assessment Monitoring System (PRAMS) by helping to fund the survey and by providing guidance on tobacco-related survey questions and analysis.

WIC: OMCH collaborates with the WIC Program to promote breast-feeding, exchange data, enhance referrals, address access to care issues between WIC and First Steps, coordinate coverage for special formulas for children covered by Medicaid, and provide cross-training. OMCH provides training and materials to WIC program staff on methods for identifying and intervening with victims of domestic violence and child abuse, and promoting good oral health practices. OMCH also collaborates with WIC through a contract with Healthy Mothers, Healthy Babies. MIH and WIC have collaborated to revise the parent education booklet entitled, "Nine Months to Get Ready", which is used for client education by WIC and Maternity Support Services providers. Given federal requirements that WIC assess DTaP immunization completion, the Immunization Program and CHILD Profile are working with WIC to determine how to use the CHILD Profile Immunization Registry to fulfill this requirement and enhance immunization rates.

Women's Health Resource Network (WHRN): WHRN is a forum for department wide input and response to current and emerging women's health issues and service gaps including data on women's health, policy

related to program services, quality assurance and standards development, and changes in the health care system. The goal of the WHRN is to assist DOH in building state and local capacity to address the needs of women and their health concerns throughout their lives. The WHRN includes representatives from 16 Community and Family Health and Environmental Health programs.

2. OMCH Relationships with Local Health Jurisdictions (LHJs)

In Washington State, OMCH contracts with 35 LHJs to address maternal and child health needs in local communities. OMCH program staff work closely with LHJs to oversee contract activities and provide consultation and technical assistance. OMCH administrators and staff meet regularly with the Nursing Directors of LHJs and other local OMCH staff through quarterly MCH Regional meetings. The OMCH provides technical assistance and data support for the local CDR teams throughout the state. Some of the activities provided by LHJs are described in the performance measure narratives.

3. OMCH Relationships with Department of Social and Health Services (DSHS)

DOH maintains close relationships with DSHS programs to best serve our similar population groups. The agencies collaborate to maximize federal administrative match, build on the strengths of each department to promote the best outcomes for clients, generate and utilize data needed by both agencies, provide coordinated program services for clients, and provide complementary services and avoid duplication.

Medical Assistance Administration (MAA): An interagency agreement between MAA and OMCH has existed for 14 years. Partnerships between OMCH and MAA have developed with the mutual goal of assuring quality health services for pregnant women, infants, children, and adolescents served by Medicaid.

OMCH staff participate on the Medicaid External Quality Review Organization Contract committee (EQRO), the MAA Early Periodic Screening Diagnosis and Treatment (EPSDT) Improvement Committee, and the MAA Immunization Partnership Committee.

MAA provides administrative match for PRAMS activities not covered by the CDC grant. PRAMS data are stratified by Medicaid recipient status and used by the First Steps program to evaluate the effectiveness of program services.

CHILD Profile's partnership with MAA resulted in matching funds for CHILD Profile activities, data sharing agreements, MAA participation in developing the health promotion materials for parents, and MAA participation in the CHILD Profile Advisory group. MAA and CHILD Profile are working jointly to maintain and expand partnerships with the state's health plans.

The CSHCN Section staff work with MAA to improve access and quality of health services for children with special health care needs through CSHCN Communication Network meetings, implementing quality assurance measures and sharing data for Title V children in Medicaid managed care. MAA and CSHCN have also worked closely to share information about undocumented children who were covered by state-funded Medicaid programs until September 30, 2002 when the state Legislature discontinued this funding. While a coverage option was provided through the Basic Health Plan for this population, all costs are not covered and a premium is required. The 2005 Legislature partially reinstated medical coverage for undocumented children. CSHCN will continue to work with MAA to monitor the utilization of this coverage.

The Immunization Program works extensively with MAA on the Vaccines for Children (VFC) Program to ensure VFC-qualified children receive adequate immunizations.

OMCH provides state funding match for Medicaid prenatal genetic counseling services. OMCH staff oversee the program and work with MAA to ensure that up-to-date billing instructions are in place. Medicaid also covers genetic counseling services for new parents up to 90 days after birth.

Medicaid Dental Program: The OMCH Oral Health Program collaborates with the Office of Medical Assistance on access to dental services for children receiving Medicaid services. OMCH and MAA both

participate on a statewide oral health coalition and meet together regularly on the Access to Baby and Child Dentistry (ABCD) Initiative and other access issues.

Division of Alcohol and Substance Abuse (DASA): OMCH actively participates in the oversight committee for developing, implementing, and evaluating a comprehensive treatment program for chemically dependent pregnant or parenting women and their young children.

Children's Administration (CA): OMCH works with CA, which has historically included Child Protective Services (CPS), Child Care, Foster Care, and other offices, on subjects of joint concern, such as chemically dependent pregnant women, child maltreatment, Child Death Review, and mental health. A cross-office and cross-agency group meets to improve services and coverage for children in foster care who are considered to be children with special health care needs.

Mental Health Division (MHD): The OMCH Mental Health Workgroup collaborates with the MHD to identify services, available data, and possible gaps. CSHCN continues to provide the MHD with data to comply with the Center for Medicaid and Medicare Services (CMS, formerly HCFA) requirements for the Medicaid 1915B waiver. This information provides the means to identify the number of children with special health care needs served by both Title V and the MHD. DOH is represented by OMCH staff on the Children's Treatment and Services subcommittee of the MHD Mental Health Planning and Advisory Committee.

Disability Determination Service (DDS) and Social Security Administration (SSA): The CSHCN program maintains a Memorandum of Agreement with DDS in order to provide information to families of children under the age of 16 who apply for SSI. DDS provides data files of all SSI applicants up to age 16 to the CSHCN program. Local CSHCN Coordinators contact families to inform them of local programs and services.

Division of Developmental Disabilities' Infant Toddler Early Intervention Program (ITEIP): OMCH is an active participant in coordinating efforts to implement Part C of the Individuals with Disabilities Education Act (IDEA). Through an Interagency Agreement with DSHS, the Department of Community, Trade and Economic Development (CTED), the Department of Services for the Blind, and Office of Superintendent of Public Instruction (OSPI); DOH works proactively with these partners to assure a comprehensive statewide system of early intervention services for eligible infants and toddlers with disabilities (birth to three years) and their families. CHILD Profile has an interagency agreement with DSHS to distribute brochures which include development information for parents of children between 3 and 18 months of age. The brochures provide parents with the resources to access early intervention services.

Office of Procedures and Policy: This DSHS program participates on the Perinatal Partnership Against Domestic Violence (PPADV). The PPADV reviews training materials, provides training and marketing of the PPADV curriculum, locates funding, and promotes awareness of domestic violence in the perinatal period. The PPADV has recently expanded its partnerships and includes multiple organizations.

4. OMCH Relationships with the Office of Superintendent of Public Instruction

OMCH maintains a collaborative partnership with OSPI through a number of programmatic efforts. The Immunization Program works with OSPI's Health Services Supervisor on issues involving immunization requirements for school entry. CAH has an interagency agreement with OSPI that pays the salary for a .5 FTE to coordinate school nurse issues. Washington State received a Coordinated School Health Grant from CDC. This is a partnership between DOH and OSPI. CSHCN and CAH participate on the Coordinated School Health Interagency Committee, and work to align this effort with related adolescent health and mental health planning initiatives. The CSHCN Program works with OSPI to identify appropriate health outcomes for children with special health care needs. OMCH also participates on an interagency team called STEPS (Sequenced Transition for Education in Public Schools) that addresses transition issues for children birth to school age. School Nurse Corps supervisors participate in MCH Regional meetings. Representatives from OSPI, CTED, DSHS, and the FPC make up the joint Healthy Youth Survey planning committee. These same organizations, along with other state and local agencies, are members of the Washington State Partnership for Youth (WSPY). The purpose of WSPY is to develop a plan for improving

adolescent health in Washington State. The CAH Youth Development Team collaborated with OSPI and other stakeholders to develop the Guidelines for Sexual Health Information and Disease Prevention as directed by the state legislature.

5. Hospitals and Other Specialized Services.

Children's Hospital and Regional Medical Center (CHRMC): OMCH works with CHRMC through a contract with the Center for Children with Special Needs (CCSN) to provide data and information to families, providers, and policy makers regarding health issues for children with special health care needs and their families. The Genetic Services section also contracts with CHRMC to provide technical assistance to birthing hospitals in Washington that are initiating or already conducting Universal Newborn Hearing Screening. CHILD Profile collaborates with CHRMC to develop and disseminate injury prevention materials for parents of children birth to six years in Washington State.

Mary Bridge Children's Hospital and Health Center (MBCHHC): MBCHHC assists CSHCN in developing and disseminating guidelines to primary care providers for the care of high-risk infants as part of their discharge plan. Additionally, MBCHHC is the site of one of 14 MCH supported neurodevelopmental centers (NDCs) and the Maxilliofacial Review Team for southwest Washington.

Regional Genetics Clinics: Six regional genetics clinics are located throughout the state and are funded to provide clinical genetic services for the MCH population as well as provide educational outreach to the communities. Data generated by the regional genetic clinics are used for program planning and policy development.

Regional Perinatal Programs: Through contracts with OMCH, four regional perinatal programs provide consultation and training to health care providers with a focus on specialized care for high-risk pregnant women and neonates.

Perinatal Advisory Committee (PAC): The statewide Perinatal Advisory Committee, staffed by OMCH, brings together representatives from tertiary care centers, professional organizations, consumer groups, and state agencies to review and assess perinatal health issues and advise DOH and DSHS, MAA in developing policies and practices to improve perinatal outcomes.

Community Health Clinics (CHC): CHCs play a major role in providing access to direct health services as LHJs continue to move toward core public health functions. Most CHCs are also First Steps MSS providers and participate in First Steps education updates sponsored by OMCH and MAA. Community Health Clinic Dental Clinics participate with the Oral Health Program to collaborate on community-based preventive oral health programs such as school sealants and as a referral base for WIC and Headstart Children.

Native American Tribes: OMCH works with the DOH tribal liaison to explore ways to expand and improve communication with tribes in Washington State. Specific actions include working with the American Indian Health Commission, expanded use of the DOH Tribal Connections website, and using expanded tribal emai contact lists for dissemination of information.

Universities and Libraries: DOH collaborates with the UW in a project using the State Capacity Grant for Prevention of Secondary Disabilities. This project is supported by a cooperative agreement with the Centers for Disease Control and Prevention to assess the types and prevalence of secondary disabilities and form local advisory councils to promote a public awareness campaign and implement strategies to prevent secondary disabilities. CHILD Profile contracts with the UW to evaluate the CHILD Profile Health Promotion System, translate materials into additional languages, and maintain the CP website.

OMCH contracts with several programs within the UW Clinical Training Unit's Center on Human Development and Disability (CHDD) through funds from an MCHB Leadership Education for Neurodevelopmental Disabilities (LEND) grant. These contracts extend and enhance MCH priorities in the areas of CHILD Profile, nutrition, high-risk infants and children, adolescent transition, medical home, and emotional behavior in very young children.

CAH works with the UW School of Education, Early Childhood, and Teen Telecommunications Network to foster leadership on issues of parents and teens and pre-teens at the state and local levels. CAH works with the UW, School of Pediatric Dentistry on oral health issues that impact pregnant women, infants, children, and youth.

6. OMCH Relationships with Other Agencies and Programs

Managed Care Plans: CSHCN staff, in partnership with MAA and LHJs, continue to work with Medicaid managed care plans to meet requirements of the CMS 1915B waiver requiring MAA to identify, track, and coordinate care for children in managed care who are also served by Title V, and to allow families to reques an exemption from managed care if needed. Plan representatives have become a part of the quarterly CSHCN Communication Network meetings. The CSHCN Program is also working with managed care plans to identify practical ways for providers to develop and provide medical homes for all children.

Foundation for Early Learning: CHILD Profile and the Foundation for Early Learning (FEL) are partnering to revise and distribute both the birth to 18 month and the 18 month for 4 years development charts for parents. The charts address social, emotion, physical, language, motor, and cognitive development and provide parents with specific activities that will support their child's development. FEL also partnered with CP to distribute a booklet titled "Getting School Ready" to parents of 4 years olds in Washington State.

F. HEALTH SYSTEMS CAPACITY INDICATORS

See Forms 17, 18, and 19 for details.

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

See Form 14 for a list of the 9 MCH population priorities that are described in detail in the comprehensive 5 year needs assessment for 2005. (See Section XA for the entire needs assessment.)

OMCH is in the process of completing the 5 year needs assessment, and is coordinating that effort with the development of a 5 year organizational and performance plan. The needs assessment describes the process and the products generated including population priorities, performance measures, activities, and outcome measures. The 5 year organizational and performance plan includes an assessment of the work we do and how we do it in relation to the 9 priorities developed through the 5 year needs assessment.

The 5 year needs assessment includes stakeholder involvement, data collection and analysis, and a thorough review of program activities to redefine the priorities for the MCH population in Washington State. The priorities developed through the 2005 needs assessment process are very similar to those developed ir the 2000 needs assessment; however, they are more universal, addressing needs across the MCH population rather than specific groups within the MCH population. This process has served to reaffirm that Washington's MCH programs are appropriately focusing resources on the most pressing needs of the MCH population in the state. In most cases, the needs reflected in these priorities are more pronounced than they were in previous years due to significant reductions, and in some cases complete elimination, of program funding at the federal and state levels, and increased economic hardship statewide.

A detailed description of OMCH's work on the national and state performance measures are provided in this section under items, "C. National Performance Measures," and "D. State Performance Measures."

B. STATE PRIORITIES

2000 -- 2004 OMCH Priorities

The following summarizes the relationship between Washington State's OMCH priorities and the state and national performance measures, outcome measures, and health systems capacity indicators for the 2000 -- 2004 Priorities.

Improving access to comprehensive prenatal care.
NPM 15, 17, 18
SPM 3, 6, 8
OM 1-5
HSCI 4, 9a

Improving oral health status and access to oral health care services.
NPM 9
HSCI 9a

Improving the coordination of services for children with special health care needs.
NPM 2 - 7
SPM 4
HSCI 1, 8, 9a

Improving early identification, diagnosis and intervention services and coordination of services.
NPM 1, 7, 12 - 14
SPM 7, 8, 10
HSCI 2, 3, 5 - 8, 9a

Decreasing family violence.
SPM 6
HSCI 9a

Decreasing unintended pregnancy and teenage pregnancy.
NPM 8
SPM 1
HSCI 9a

Improving mental health status.
NPM 16
SPM 7
HSCI 9a

Ensuring surveillance capacity for children with special health care needs.
SPM 4
HSCI 9a

Decreasing tobacco use.
SPM 2, 5, 8
HSCI 9a, 9b

Improving nutritional status.
NPM 11
SPM 9
HSCI 9a, 9c

NOTE: For the 2000 - 2004 Priorities, one performance measure and one outcome measure (NPM10 and OM 6), are not directly addressed, but are addressed by OMCH through partnership and collaboration with our partners in the Injury Prevention Program.

2005 -- 2009 OMCH Priorities

As part of the 2005 Five Year Needs Assessment, OMCH developed nine priorities. Attached is a crosswalk between the 2000 - 2004 priorities and the new 2005 - 2009 priorities and a crosswalk between the old state performance measures and the new state performance measures. As the 2005 Needs Assessment is finalized, more state performance measures will be developed based on the nine priorities established in the needs assessment process and added to the 2007 MCH Block Grant Application.

The following summarizes the relationship between Washington State's OMCH priorities and the state performance measures at this stage of development, national performance measures, outcome measures, and health systems capacity indicators.

Appropriate nutrition and physical activity for the MCH population
NPM 11, 15
OM 1-5
SPM 7
HSCI 5, 9a, 9c
HSI 1a-b, 2a-b

Lifestyles free of substance use and addiction among adolescents and women
NPM 10, 15
OM 1-5
SPM 2, 3
HSCI 1, 9b
HSI 1a-b, 2a-b, 3a-c, 4a-c

Optimal mental health and healthy relationships

NPM 2, 6, 11, 16
OM 6
SPM 4
HSCI 4

Healthy physical and social environments/communities for the MCH population
HSCI 1, 9c

Safe environments/communities for the MCH population
NPM 10, 16
OM 6
SPM 3
HSI 3a-c, 4a-c

Healthy physical, emotional, cognitive and social development of all children
NPM 6, 11, 12
SPM 4, 8

Sexually responsible and healthy adolescents and women
NPM 8, 18
SPM 1, 3
HSCI 4
HSI 5a-b

Access to preventive and treatment services for the MCH population
NPM 3-7, 9, 12-14, 17-18
OM 1-5
SPM 1, 3, 6, 7
HSCI 3-8

Screening, identification, intervention, and care coordination for the MCH population
NPM 1-3, 5-7, 9, 12, 17, 18
OM 1-5
SPM 3 ,4, 6, 8
HSCI 2-5, 7

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		99.5	99.6	99.7	99.7
Annual Indicator		93.6	93.9	89.3	100.0
Numerator		44	46	50	69
Denominator		47	49	56	69
Is the Data Provisional				Final	Final

or Final?					
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	95	96	97	98	99

Notes - 2002

The percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinapathies with appropriate referral.
These data come from Form 6. The numerator is the number of live born infants born in Washington that were reported by the Office of Newborn Screening as screened and were a confirmed case that received treatment . The denominator is the number that were screened and were a confirmed case. In 2001, 99.7% of newborns received a newborn screening. The state currently screens for adrenal hyperplasia, PKU, hypothyroidism, and hemoglobinopathies. Washington does not screen for galactosemia. See Form 6 for details on conditions.

Notes - 2003

The percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, hemoglobinapathies, and congenital adrenal hyperplasia with appropriate referral.
These data come from Form 6. The numerator is the number of live born infants born in Washington that were reported by the Office of Newborn Screening as screened and were a confirmed case that received treatment. The denominator is the number that were screened and were a confirmed case. In 2003, 98.7% of newborns received a newborn screening. The state currently screens for adrenal hyperplasia, PKU, hypothyroidism, congenital adrenal hyperplasia, and hemoglobinopathies. Washington began screening for galactosemia in FFY 2003. See Form 6 for details on conditions.

Notes - 2004

The percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, hemoglobinapathies, and congenital adrenal hyperplasia with appropriate referral.
These data come from Form 6. The numerator is the number of live born infants born in Washington that were reported by the Office of Newborn Screening as screened and were a confirmed case that received treatment. The denominator is the number that were screened and were a confirmed case. In 2004, 100%% of newborns received a newborn screening. The state currently screens for adrenal hyperplasia, PKU, hypothyroidism, congenital adrenal hyperplasia, and hemoglobinopathies. Washington began screening for galactosemia in FFY 2003. See Form 6 for details on conditions.

PERFORMANCE OBJECTIVES: Future targets were chosen from a combination of Maternal and Child Health staff discussions and trend analyses.

a. Last Year's Accomplishments

The Washington State Board of Health (SBOH) adopted the revised dried blood spot regulations at their regular meeting on October 15, 2003 and DOH began developing plans to implement expanded screening for five additional disorders. Screening for biotinidase deficiency and galactosemia was added to the mandatory panel of disorders on January 1, 2004. The other three disorders (homocystinuria, medium chain acyl-co-A dehydrogenase (MCAD) deficiency, and maple syrup urine disease (MSUD)) were added on June 1, 2004. This involved using the state-of-the-art tandem mass spectrometry where multiple disorders can be detected using one blood spot. The equipment was installed, staff was trained, data systems were updated, laboratory procedures and follow-up protocols were developed, and disease-specific educational materials for providers and parents were created.

CHILD Profile continued mailing the Health and Development Record that includes a message to encourage parents to talk with their provider about health screenings and provides a centralized area to record screenings, such as: the second newborn blood spot screening, hearing screening, vision, and lead screening. The Health and Development Record is available in English and Spanish and is disseminated in the postpartum packet that arrives four to six weeks after a child is born. This mailing is sent to approximately 86% of the annual birth population of approximately 80,000. (Fig. 4a, NPM 1,

Act. 3)

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor every non-military baby born in Washington for appropriate screening, and follow up on those with incomplete testing.				X
2. Contract with pediatric specialists and comprehensive care clinics to provide expert diagnostic and treatment services for infants with abnormal screening results.				X
3. Update and develop new professional and lay educational information via different venues: website, provider manual, on-site hospital visits, disorder-specific fact sheets and pamphlets, etc.				X
4. Determine family eligibility for financial and support services and coordinate through state and county CSHCN programs and medical homes.		X		
5. Purchase and distribute medically necessary formulas and low-protein foods for individuals with PKU and other metabolic disorders.		X		
6. Collect long-term outcome data to evaluate the benefit of various components of treatment, compliance, and intervention.				X
7. Develop a data system linking newborn screening records with hearing screening.				X
8.				
9.				
10.				

b. Current Activities

Per a motion by the SBOH, the department established and convened a Cystic Fibrosis Technical Review Committee. The purpose was to review new information available on the benefits of newborn screening for cystic fibrosis and making a preliminary determination whether this condition meets criteria established for newborn screening tests in Washington. The committee found sufficient evidence for screening newborns for the condition. Now a Newborn Screening Advisory Committee comprised of a broad representation of stakeholders will be convened to further consider the issues and make recommendations to the SBOH.

DOH will be working with the SBOH to review the recommendations of the American College of Medical Genetics (ACMG) regarding a uniform national newborn screening panel.

To help refine the diagnosis and clinical prognosis of galactosemia and a clinically significant hemoglobinopathy (a form of alpha thalassemia), we implemented real-time polymerase chain reaction in the Newborn Screening Laboratory. This allows us to obtain DNA results in far less time and at a lower cost. We also plan to expand DNA testing for MCAD deficiency.

CHILD Profile is mailing the Health and Development Record that includes a message to encourage parents to talk with their provider about health screenings and provides a centralized area to record screenings, such as: newborn blood spot and hearing screening, vision, and lead screening. This year, CHILD Profile asked several parent and professional review teams for their input on the usefulness, layout, and information contained in the record. CHILD Profile is making significant revisions to the record and will begin mailing the new version in May 2005. The Health and Development Record is available in English and Spanish and is distributed in the postpartum packet

that arrives four to six weeks after a child is born. This mailing is sent to about 86% of the annual birth population of approximately 80,000. (Fig. 4a, NPM 1, Act. 3)

c. Plan for the Coming Year

During this year, the department will continue to expand and refine our screening protocols, particularly for any newly added disorders to the newborn screening panel. Necessary adjustments and revisions will be made based on department experience and that of other newborn screening programs.

Depending on the outcome of the review process described above, DOH anticipates adding cystic fibrosis screening during this period.

DOH will continue working with the SBOH to determine Washington's response to the recommendations of the ACMG regarding a uniform national screening panel.

CHILD Profile will revise and continue distributing the Health and Development Record as part of the postpartum packet (dependent upon securing additional funding to support future development and dissemination of the material) sent to Washington State parents 4-6 weeks after the birth of their child. (Fig. 4a, NPM 1, Act. 3)

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				54.9	54.9
Annual Indicator			54.9	54.9	54.9
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	56	56.5	57	57.5	58

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS. A target for this performance measure will be established next year once the data from SLAITS has been analyzed.

Notes - 2003

The source is the CHSCN Survey from the MCHB. No new data were available.

Notes - 2004

The source is the CHSCN Survey from the MCHB. No new data were available

PERFORMANCE OBJECTIVES: Future targets were chosen from a combination of Maternal and Child Health staff discussions and trend analyses.

a. Last Year's Accomplishments

Through the contract with Children's Hospital and Regional Medical Center (CHRMC), a CSHCN Road Show was developed using Washington State data from the National CSHCN Survey. The Road Show was presented to local health agencies, parent organizations, health plans, and other stakeholders. Discussions with these groups helped prioritize further projects and activities and provided input to the CSHCN Program priorities for the MCH 5 year needs assessment. (Fig. 4a, NPM 2, Act. 1)

In November 2003, the Medical Home Leadership Network (MHLN) and the CSHCN Program, Washington Integrated Services Enhancement (WISE) Grant collaboratively hosted a leadership training called "Taking a Leadership Role to Create Family-Professional Partnerships in Washington State." The audience included a wide spectrum of cross-agency and community-based parent leaders working on WISE Grant integration and health systems development at the state and local levels.

The CSHCN Program provided leadership for inclusion of the family perspective in policy and program development through its family consultant and the Family Leadership Plan.

The CSHCN Communication Network involved parent organizations as participants and presenters. During the past year, presentations focused on mental health, respite care, and serving culturally diverse families. Each of these presentations included at least one family member on the panel. (Fig. 4a, NPM 2, Act. 2)

All LHJs have a staff person designated as the CSHCN Coordinator. This person works with families to coordinate services for the child, which includes parents' involvement and reflects the parents' goals for the child. CSHCN Coordinators work closely with their county's Birth to Three Program, schools, and parent support groups, especially Parent to Parent.

Activities of special note included development of an Individualized Education Plan Class, as had been requested during the WISE grant needs assessment phase. The class was done in cooperation with Family Educator Parent Partnership, Parent to Parent, and the local school district; and received positive reviews and requests to have it presented in other school districts. Additionally, a meeting for parents of children with special health care needs was held with their local county and state representatives, and school district personnel. Twenty-two parents attended.

Another county gave presentations to parent groups to highlight and discuss specific community resources for children with special needs and to share ideas for parents to successfully advocate for services.

A third county piloted a parent administered developmental screening tool to several families in their community. Families returned the questionnaire and were then contacted, given information about concerns, and accessing services. By administering the questionnaire themselves, parents are more knowledgeable and able to express concerns to health care providers.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Contract with CCSN at CHRMC to provide ongoing analysis of available data on children with special needs, including NCSHCN Survey for state-specific analysis.				X
2. Ensure family representation in policy development through MHLN, WISE,				

and FAN contracts with LHJs and other contractors and through ongoing dialogue at CSHCN Communication Network meetings.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The CSHCN Program contracted with CHRMC to create a data publication that provides a comprehensive picture of children with special health care needs both locally and statewide using the National CSHCN Survey, county profiles, and results of other assessment activities. An introduction of this publication was provided at a CSHCN conference in May 2005 with final release planned in July 2005. (Fig. 4a, NPM 2, Act. 1)

At the fall 2004 Family Leadership Institute, parents attended a variety of leadership sessions, including a workshop on data and using the National CSHCN Survey, and were introduced to all the national performance measures for children and youth with special needs. Child and Adolescent Health Measurement Initiative partnered with Family Voices to conduct workshops designed to increase parents' use of data and ways to promote data in various leadership roles. Pre- and post-conference surveys provided information on ways to involve family leaders in decision-making and integrating systems of care at all levels.

The CSHCN Program continues to provide leadership to include the family perspective in policy and program development, and promotes quality, integrated systems of care for children with special needs and their families. The CSHCN Program developed new partnerships with cross-agency and community organizations and other family support programs to further integration of systems goals including integrated care coordination, common application, integrated data, and blended funding strategies that include input from families.

Family Advisory Network parents took on leadership roles for the WISE Grant. The CSHCN Program collaborated with the Washington Family to Family Network (WFFN) to develop the statewide Family Leadership Plan. WFFN refined their vision and purpose statement and addressed long-term strategic planning to address the national performance measures. The CSHCN Program assisted in developing cross-agency linkages on the Healthy Mothers Healthy Babies, Answers for Special Kids (ASK) Resource Line website, and was able to have pictures of fathers and youth added to ASK Line materials.

The CSHCN Communication Network continues to involve parent organizations and parents. Meetings during this time focused on transition from early intervention programs to school; SSI for children; the foster care system; and local collaborations between public health nurses and families.

The CSHCN Program contracts with Washington State Parent to Parent and Washington State Fathers Network to provide support and resource information to parents of children with special needs. Parents continue as members of feeding teams and are supported through a contract with the CHDD at the UW. Guidelines on the development of community-based feeding teams were revised and posted electronically. (Fig. 4a, NPM 2, Act. 2)

c. Plan for the Coming Year

The CSHCN Program will contract with CHRMC to review available data and develop additional baseline measurements to provide additional information on this performance measure. (Fig. 4a, NPM 2, Act. 1)

The CSHCN Program and the program's family consultant will continue to promote inclusion of the family perspective in all OMCH programs activities and planning. The CSHCN Program, and especially the family consultant, will continue to take a leadership role in identifying and implementing strategies to increase the number of families involved as decision-makers and who are satisfied with the services they receive. Program contractors will continue to involve families as an integral component to achieving and measuring satisfaction with services.

The CSHCN Program, in conjunction with WFFN, will update the Family Leadership Plan to include integrated, cross-program, cross-contract work and opportunities within the national performance measures. The Family Advisory Network and other family consultants will continue to be mentored and provided with opportunities to take leadership roles within the areas of the national performance measures.

Parent involvement as regular participants and as special presenters will continue in the Communication Network meetings.

A network of community-based feeding teams with parents as members will continue to be supported through a contract with the UW. (Fig. 4a, NPM 2, Act. 2)

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				53.6	53.6
Annual Indicator			53.6	53.6	53.6
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	53	53	53	53	54

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS. . A target for this performance measure will be established next year once the data from SLAITS has been analyzed.

Notes - 2003

The source is the CHSCN Survey from the MCHB. No new data were available.

Notes - 2004

The source is the CHSCN Survey from the MCHB. No new data were available.

PERFORMANCE OBJECTIVES: Future targets were chosen from a combination of Maternal and

Child Health staff discussions and trend analyses.

a. Last Year's Accomplishments

The CSHCN Program contracted with CHRMC to analyze the Washington State data from the National Survey of CSHCN and prepared the information for the CSHCN "Road Show". Statewide meetings were held for local health, parent organizations, health plans, and other stakeholders. These groups cited needs for more information about access to specialty and mental health services that can be better addressed in a medical home environment.

The CSHCN Program's Child Health Intake Form (CHIF) automated data system provides information about the number of children served by community-based CSHCN Programs considered as having a medical home. CHRMC used the data from the CHIF program to enhance other data in assessing needs of children served in the program. (Fig. 4a, NPM 3, Act. 1)

The CSHCN Program continues to support the MHLN and the Adolescent Health Transition Project (AHTP) at the UW's Center for Human Development and Disability (CHDD), Mary Bridge Children's Hospital and Health Center (MBCHHC), and CHRMC in developing and piloting their medical home initiatives and projects. The CSHCN Program provided ongoing leadership training and support to implement community-based initiatives.

The needs of low birth weight and extremely low birth weight infants in medical homes were addressed in "Watching your Low Birth Weight Infant Grow", developed by MBCHHC.

Separate MCHB funding to the MHLN ended in March 2004. The final evaluation of the project will identify strategies for approaching physicians in order to increase the number of medical homes statewide. Additionally, the percent of health plans who consider themselves as providing medical homes will be calculated using 2002 CAHPS survey data.

In fall 2003, the WISE Grant partnered with MHLN to sponsor family attendance at their annual conference and to provide a second day for teaching skills to promote medical homes.

WISE Grant pilot sites include members of local medical home teams on their local steering committees to incorporate medical homes into community systems of care. (Fig. 4a, NPM 3, Act. 2)

Maxillofacial Review Teams and CSHCN Coordinators continue to have exposure to new products and resources in order to encourage physicians to adopt the medical home model.

LHJs were encouraged to include involvement in their local medical home teams in their MCH contracts. Seventeen CSHCN Coordinators currently are members of their local medical home team. One example of a local activity is an LHJ who implemented medical home training with local pediatricians and plans to meet with them 2 to 4 times yearly to maintain relationships and discuss services, including potential duplication of services. (Fig. 4a, NPM 3, Act. 3)

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Contract with CCSN at CHRMC to provide ongoing analysis of available data on children with special needs, including the NCSHCN Survey and the CAHPS.				X
2. Support the MHLN and the Medical Home grant through staff involvement and leadership to increase awareness of medical homes statewide.				X
3. Contract with LHJs for activities that increase awareness of, and access to,				

medical homes within their communities.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The CSHCN Program contracted with CHRMC to create a data publication that will provide a comprehensive picture of children with special health care needs both locally and in Washington State using the National Survey of CSHCN, county profiles, and results of other assessment activities. Release of this publication is scheduled for July 2005. (Fig. 4a, NPM 3, Act. 1)

Support of the current and ongoing activities of MHLN continues with funding from our program, staff involvement and leadership. The CSHCN Program contracted for a survey of medical home physician team members to identify targeted education strategies for promoting medical homes, recruiting new medical home teams, and building the agenda for the Fall 2004 action meeting. Additionally, MHLN analyzed data from the 2004 key informant interviews of parents who attended the Center on Human Development and Disability Clinic to provide medical home strategies for outpatient clinic settings. An evaluation of the Child Health Notes is underway which will provide strategies for statewide use and design improvements. Family members of MHLN teams and the project's co-director were involved in the Family Leadership Institute, where training on the national performance measure on developing medical homes for all children was presented.

Methods to determine how to better integrate the MHLN with the CSHCN Nutrition Network and network of community-based feeding teams is underway.

The CSHCN Program contracted with MBCHHC to disseminate and provide training on the low birth weight Critical Elements of Care and "Watching your Low Birth Weight Infant Grow".

The WISE Grant will give attention to current work defining the role of the care coordinator and the importance of seamless care coordination. Additional pilot sites, which will incorporate medical home teams and the role of a medical homes in coordinated care for a child and family, will be encouraged and developed. (Fig. 4a, NPM 3, Act. 2)

Support continues for Maxillofacial Review Teams. Additional opportunities for training, technical assistance, resources, and materials were made available to local CSHCN Coordinators. Maxillofacial Review Teams were encouraged to promote family-centered care and medical homes in their regular review boards. Language to include family-centered care and medical homes was included in the maxillofacial contracts.

Contract year-end reports from local health jurisdictions will be reviewed for activities related to medical home teams, and information shared as appropriate. (Fig. 4a, NPM 3, Act. 3)

c. Plan for the Coming Year

The CSHCN Program will contract with CHRMC to review available data and develop additional baseline measurements to provide additional information on this performance measure. (Fig. 4a, NPM 3, Act. 1)

The CSHCN Program will incorporate findings from the WISE Grant into care coordination system

activities across state agencies, and will contract with the MHLN at CHDD to assemble, disseminate, and evaluate care coordination tools. The CSHCN Program's Nutrition Consultant will initiate a plan to better integrate the MHLN with the CSHCN Nutrition Network and the network of community-based feeding teams. (Fig. 4a, NPM 3, Act. 2)

The importance of medical homes for all children will continue to be a topic of CSHCN Coordinator meetings both regionally and at the state level. Information gathered from the MHLN evaluation survey will be shared with all CSHCN Coordinators. Medical home team participation will be encouraged as part of the CSHCN Coordinator's public health role in the community.

The CSHCN Program will continue to support the Maxillofacial Review Boards and provide ongoing information regarding medical homes. Increasing family-centered care will continue to be written into maxillofacial contracts. (Fig. 4a, NPM 3, Act. 3)

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective				64.4	64.4
Annual Indicator			64.4	64.4	64.4
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	63	63	63	63	69.5

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS. . A target for this performance measure will be established next year once the data from SLAITS has been analyzed.

Notes - 2003

The source is the CHSCN Survey from the MCHB. No new data are available.

Notes - 2004

The source is the CHSCN Survey from the MCHB. No new data were available

PERFORMANCE OBJECTIVES: Future targets were chosen from a combination of Maternal and Child Health staff discussions and trend analyses.

a. Last Year's Accomplishments

The CSHCN "Road Show," developed jointly through the contract with CHRMC, provided initial results of the National Survey of CSHCN. The Road Show was presented to groups of local health agencies, parent organizations, health plans, and others. These groups indicated a need to know more about children on Medicaid managed care and children with fee-for-service Medicaid coupons, especially concerning access to specialty care. Parental employment status among responders to the survey was requested because it could indicate gaps in insurance coverage for children. Information

about sources of payment for respite care as part of health coverage was also of interest. (Fig. 4a, NPM 4, Act. 1)

Criteria were agreed upon, finalized, and incorporated into the software developed by Strategic Services for the CHIF database. Beginning January 2004, all local health staff were using more uniform standards to increase completeness and comparability of the data, including source of insurance for health care.

CSHCN continued to earmark diagnostic and treatment funding for medically necessary services not covered by any other source, including undocumented children with special needs who lost other state coverage.

Work continued with CHRMC and pilot sites to collect nutrition assessment data on children with special health care needs and manipulate a data system to generate results. A report template based on nutrition data collected in Spokane from 1996-2003 was developed. A cost analysis report on the benefits of having a reimbursement system in place for nutrition services and nutrition supplements was completed. Hard copies were distributed and an electronic version of the report was posted on the OMCH/CSHCN website. (Fig. 4a, NPM 4, Act. 2)

The CSHCN Program's quarterly Communication Network meeting, which includes case managers from managed care plans who cover both Medicaid and private insurance customers, continued to share concerns and discuss solutions. Monthly meetings of the Medicaid Integration Team (MIT) with representatives of Medicaid managed care and fee-for-service, and from Basic Health Plan continued to probe issues about health coverage.

The CSHCN Program continued to develop trainings to assist families and care coordinators in understanding how to navigate health service systems. A presentation, "Paying the Bills", was made by the CSHCN Nurse Consultant and Family Consultant at the April 2004 Early Childhood Conference. (Fig. 4a, NPM 4, Act. 3)

The CSHCN Program reviewed information from a survey documenting requests for services from LHJs for non-citizen children. They then developed strategies to pursue providing medically necessary services. The information was aggregated and shared with partners. Legislative action in 2004 established premiums for children who were eligible for Medicaid. The Governor responded by putting a moratorium on premiums until July 2005. (Fig. 4a, NPM 4, Act. 4)

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Contract with CCSN at CHRMC to provide ongoing analysis of available data on children with special needs, including the NCSHCN Survey and the CAHPS.				X
2. Collect and analyze statewide program information from CHIF and Health Service Authorizations to identify children who have insurance.				X
3. Collaborate through various interagency forums such as Communication Network, Medicaid Integration Team, and interactions with managed care plans.				X
4. Provide limited diagnostic and treatment funds to fill gaps in services for children with the CSHCN Program, including those for undocumented children with special needs.		X		
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities

To assist in the development of the MCH 5 Year Needs Assessment, additional insurance data from the National Survey of CSHCN is being analyzed for use in planning priorities. In anticipation of the release of the 2005 National Survey of CSHCN, strategies for further analysis of the data and use of insurance data are being considered for incorporation into the state level publication to be released in 2005.

Insurance coverage is specifically addressed in the data publication currently being finalized which will provide a comprehensive picture of children with special health care needs both locally and in Washington State. Data includes that from the CSHCN National Survey, county profiles, and results of other assessment activities. (Fig. 4a, NPM 4, Act. 1)

The CHIF database undergoes quality checks each quarter when data is submitted. Of special consideration are those data elements which were impacted by changes in data entry requirements. Through the CSHCN Program's contract with Strategic Services, consultation and training to local public health agencies continues to ensure quality for all data items, including source of insurance for children in the system.

CSHCN continues to provide limited diagnostic and treatment funds to fill the gaps in medically necessary services not covered by any other source.

Work continued with CHRMC and pilot sites to collect nutrition assessment data on children with special health care needs and manipulate a data system to generate results. A report template based on nutrition data collected in Spokane from 1996-2003 was developed. The CSHCN Nutrition consultant completed a report on CSHCN Special Formula Fund usage (1987 -- 2004) and distributed it to CSHCN Coordinators and other stakeholders. (Fig. 4a, NPM 4, Act. 2)

Interagency collaboration through various forums such as the Communication Network and MIT, and interaction with managed care plans continues. Ways to connect with more commercial insurance plans has resulted in a new collaboration with Group Health Cooperative. The CSHCN Program and the MAA continue to address concerns on coverage issues for children on Medicaid, reviewing systems issues that impact solutions.

The CSHCN Program is reviewing and updating parent and provider resource information contained in the publication, "Paying the Bills." (Fig. 4a, NPM 4, Act. 3)

The CSHCN Program continued to monitor the use of diagnostic and treatment funds for undocumented children with special health care needs, and shared information with partners as appropriate. Information from the anecdotal survey from CSHCN Coordinators on the effects of Medicaid loss for undocumented children was included in the Kaiser Report on Medicaid and the uninsured. Premiums for children on Medicaid were again addressed in the 2005 legislative session and the prior year's legislation was modified to only levy premiums on children in families at 150% of the FPL and above. (Fig. 4a, NPM 4, Act. 4)

c. Plan for the Coming Year

The CSHCN Program will contract with CHRMC to review available data and develop additional baseline measurements to provide additional information on this performance measure. The CSHCN

Program's Nutrition Consultant will work with CHRMC and dietitians in Spokane to complete a nutrition report on CSHCN from 1996-2003. (Fig. 4a, NPM 4, Act. 1)

The CSHCN Program will continue to monitor standards in the Child Health Intake Form data collection system to measure quality, including third-party payment sources for medical coverage. Strategic Services will continue to assist local health in data quality improvement.

Plans for the dissemination of the results of nutrition assessment data for children with special health care needs will be determined. (Fig. 4a, NPM 4, Act. 2).

Interagency collaboration through various forums such as the Communication Network and MIT, and interaction with managed care plans will continue. Ways to connect with more commercial insurance plans will continue to be attempted. Legislation to use state funds to provide Medicaid coverage to undocumented children whose families are below 100% of the federal poverty level was passed, and the CSHCN Program has been asked to work with MAA partners to develop a plan and to assist in outreach enrollment efforts. The program will also monitor the effects of this on enrollment in local CSHCN Programs. The CSHCN Program will continue to address coverage issues for children on Medicaid, particularly concerns about upcoming changes to Medicaid coverage for nutrition products. (Fig. 4a, NPM 4, Act. 3)

The CSHCN Program will continue to earmark limited diagnostic and treatment funding for medically necessary services not covered by another source to fill the gaps in services for children with special health care needs, including undocumented children. (Fig. 4a, NPM 4, Act. 4)

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective				74.1	74.1
Annual Indicator			74.1	74.1	74.1
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	74.6	74.6	74.6	74.6	78

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS. . A target for this performance measure will be established next year once the data from SLAITS has been analyzed.

Notes - 2003

The source is the CHSCN Survey from the MCHB. No new data were available.

Notes - 2004

The source is the CHSCN Survey from the MCHB. No new data were available

PERFORMANCE OBJECTIVES: Future targets were chosen from a combination of Maternal and Child Health staff discussions and trend analyses.

a. Last Year's Accomplishments

The CSHCN Program contracted with CHRMC to conduct sub-analyses of the National Survey of CSHCN to further address this performance measure. Presentations for local health, parent organizations, health plans and other stakeholders proved that data from other agencies and programs, including early intervention programs, schools and tribes, was of great interest in helping determine how community service systems were working for children and families. (Fig. 4a, NPM 5, Act. 1)
A public agency system assessment was conducted to identify potential barriers in integration models. WISE Grant staff and the steering committee prepared a briefing document with recommendations for statewide system integration A retreat for WISE Grant stakeholders was held to review social marketing concepts and process. (Fig. 4a, NPM 5, Act. 2)

The CSHCN Communication Network continued to be the conduit for questions from local CSHCN Coordinators who encounter systems difficulties as they work with children and families. Most concerns were about Medicaid coverage and communication/collaboration either among agencies at the local level or from tertiary care centers to local Coordinators.

The CSHCN Program contracted with CHRMC to collect resource information for families for web posting. CSHCN Coordinators provided the information from their county to be included on this website.

Most LHJ CSHCN Coordinators are active participants on their Community Interagency Coordinating Council and many work with or lead local coalitions and workgroups to address specific issues for children with special needs in their communities.

Specific local CSHCN Coordinator activities to promote organized systems included collaboration with Head Start and early learning educators and hospital nursing staff; providing internet training to parents including evaluating sites; developing a local website with resources and information for parents and providers; and coordinating a multi-site, county-wide free Child Find screening.

Through an information-gathering process with the WorkFirst Program, Children with Special Needs Initiative at DSHS, the CSHCN Program identified barriers and gaps in services that inhibit parents of children with special needs from participating in the WorkFirst Program. (Fig. 4a, NPM 5, Act. 3)

The CSHCN Program continued to support the infrastructure of 14 neurodevelopmental centers.

Additional support for community agency collaboration was addressed in the contract supporting the ASK Line at HMHB. New data elements were requested and added to the ASK Line data collected on callers in order to know more about the needs of the children. County Resource Lists were developed and ASK Line web linkages were enhanced to provide more community level information for families and providers. (Fig. 4a, NPM 5, Act. 4)

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Contract with CCSN at CHRMC to provide ongoing analysis of available data on children with special needs, including the NCSHCN Survey and CAHPS.			X	
2. Develop and implement policy based on the outcome evaluation from WISE				

pilots regarding community care coordination.			X	
3. Maintain the network of CSHCN Coordinators and interagency collaborations to provide forums for system improvement that include families as partners; and provide learning opportunities about local, state, and national systems for children with specia				X
4. Contract with Neurodevelopmental Centers (NDCs) to support community-based collaborations among NDCs, local health agencies, and other partners.	X			
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CHRMC is completing the data publication which includes both local and statewide data on children with special health care needs. It contains data from the National Survey of CSHCN, county profiles, and results of other assessment activities. The publication will be ready for dissemination summer 2005.
Following the information about data needs from the state's MCH 5 Year Needs Assessment, additional data from the National Survey of CSHCN is being analyzed for use in planning priorities. (Fig. 4a, NPM 5, Act. 1)

WISE Grant pilot sites continue to test care coordination models. Families continue to be an active part of policy development through their participation on the Care Coordination subcommittee and participation in a Family Advisory Network conference and focus groups. A final evaluation of the WISE Grant pilot site projects will include family interviews and feedback on community-based services. Final recommendations from the WISE Grant sub committees on care coordination, integrated data, and common enrollment will be developed and distributed to stakeholders. (Fig. 4a, NPM 5, Act. 2)

Ways of better integrating the Medical Home Leadership Network with the CSHCN Nutrition Network and networks of community-based feeding teams have been developed to improve access to an array of coordinated services for families with children with special health care needs.

The CSHCN Program maintains the network of CSHCN Coordinators and interagency collaborations and to provide forums that include families as partners. Problem-solving has become expedited by having the critical partners at the same place, discussing not only the problems, but programmatic limitations and possible solutions.

A model for successful community collaborations between Parent to Parent and CSHCN Coordinators was presented at a statewide CSHCN Coordinator conference in May 2005, which focused on partnerships and integration of care for children. The first day was filled with presentations and breakout sessions on topics of data, autism, grief and loss, treatment for premature infants, social marketing, and more. An education showcase featuring several non-profit and family organizations provided the attendees information they could use for their own communities. The second day featured four panels addressing integration of care among state and local agencies and organizations.

The CSHCN Program continues to be involved in the WorkFirst Program at DSHS, collecting and summarizing information to identify gaps in services for families of children with special health care needs. (Fig. 4a, NPM 5, Act. 3).

The CSHCN Program supports the infrastructure of 14 neurodevelopmental centers, the ASK Line, and other contractors in order to obtain pertinent information about the children and families involved with them. (Fig. 4a, NPM 5, Act. 4)

c. Plan for the Coming Year

The CSHCN Program will contract with CHRMC to review available data and develop additional baseline measurements to provide additional information on this performance measure. (Fig. 4a, NPM 5, Act. 1)

The CSHCN Program will complete an assessment of the WISE Grant and develop final recommendations for improving state services for children with special health care needs. The recommendations will be disseminated to key stakeholders and will include information regarding care coordination, common application, data integration, and blended funding. (Fig. 4a, NPM 5, Act. 2)

Interagency collaboration will continue with the WorkFirst Children with Special Needs Initiative between the CSHCN Program, Department of Social and Health Services, and the CSHCN Coordinators to provide services to children and families participating in the WorkFirst Program.

The CSHCN Program will continue to maintain the network of CSHCN Coordinators and interagency collaborations and provide forums that include families as partners. A plan will be implemented to better integrate the network of community-based feeding teams into both the CSHCN Nutrition Network and the MHLN teams to improve access for children seen by feeding teams to a wider array of community-based services.

CSHCN Coordinators and the CSHCN Program will develop tools for providers and families to assist providers in care coordination. Families will be asked for input into the care coordination tools. The program will post a short-term survey on selected contractors' websites to identify types of users, assess gaps in target audiences, and prevent duplication. (Fig. 4a, NPM 5, Act. 3)

CSHCN Program will continue to support neurodevelopmental centers, the ASK Line, and other contractors in order to maintain current and ongoing sources of reliable information about the children and families involved with them. (Fig. 4a, NPM 5, Act. 4)

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					
Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective				5.8	5.8
Annual Indicator			5.8	5.8	5.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**

Annual Performance Objective	8.3	8.3	8.3	8.3	14.3

Notes - 2002

Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted.. A target for this performance measure will be established next year once the data from SLAITS has been analyzed.

Notes - 2003

The source is the CHSCN Survey from the MCHB. No new data were available.

Notes - 2004

The source is the CHSCN Survey from the MCHB. No new data were available

PERFORMANCE OBJECTIVES: Future targets were chosen from a combination of Maternal and Child Health staff discussions and trend analyses.

a. Last Year's Accomplishments

The Adolescent Health Transition Projects (AHTP) Health History Summary findings showed that youth who participated in the health history summaries, along with their families, were more likely to take active roles in their own health care. The findings were submitted to Exceptional Parent for possible publication in the journal.

The Adolescent Health Transition Resource Notebook was evaluated by a number of readers, including parents from diverse ethnic cultures. Feedback was incorporated into the current version and plans made to expand the notebook to include more family stories from a variety of cultures. Artwork by youth with special needs was commissioned as a cover and chapter dividers. The notebook has been widely disseminated and in-services conducted. (Fig. 4a, NPM 6, Act. 1)

The AHTP collaborated more closely with the Medical Home Leadership Network and explored the potential of adult medical homes for adolescents and youth. (Fig. 4a, NPM 6, Act. 2)

The CSHCN "Road Show", developed from the data analysis done through the contract with CHRMC, also highlighted information in the survey regarding adolescents even though this was very limited. The discussions with stakeholders at these presentations provided input about other sources of data and other questions regarding adolescents' needs. (Fig. 4a, NPM 6, Act. 3)

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Contract with the University of Washington, Adolescent Health Transition Project to provide transition information about federal, state, and community programs and services.				X
2. Partner with the CAH Section, OSPI, FEPP, DDD, and DVR to enhance transition services and access to them.				X
3. Contract with the CCSN at CHRMC to provide analysis of available data, including the NCSHCN Survey, on adolescents with special needs.				X
4.				
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities

The Adolescent Health Transition Resource Notebook has been updated to include a section on culturally diverse transition stories, sexuality, and HIPAA regulations/privacy issues. In-services on how to use the notebook are being provided by the AHTP staff and the Family Educator Partnership Project, focusing on schools and school nurses, as well as other audiences.

A new health insurance document is being developed in conjunction with the Office of the Insurance Commissioner to assist adolescents with special health care needs transitioning into adulthood.

AHTP staff is developing a work plan based on research into the use of youth advisory boards in planning and policy development for adolescent services. Exploration of how best to recruit, mentor, and involve youth in addressing issues of importance to adolescents with special needs in this state is ongoing. (Fig. 4a, NPM 6, Act. 1)

In response to the Medical Home State Plan (MHSP) goals of increasing awareness and existence of medical homes for children and adolescents with special needs, the AHTP is formulating a five-year plan to improve adolescent health transition in Washington State. AHTP is seeking input from the CSHCN Program, Child and Adolescent Program, and other partners of the MHSP, including the Washington Chapter of the American Academy of Pediatrics representative, the Center for Children with Special Needs at CHRMC, family physicians, and others. (Fig. 4a, NPM 6, Act. 2)

The CSHCN Program's contract with CHRMC began a process to develop care plans for adolescents. Focus groups of adolescents, parents, and providers were identified to provide further input in the next contract year to assist in planning for transition to adult medical care. (Fig. 4a, NPM 6, Act. 3)

c. Plan for the Coming Year

The CSHCN Program will collaborate with the Adolescent Health Transition Project at the University of Washington to develop a 5 year strategic plan for providers, youth, and families to facilitate adolescent transition. (Fig. 4a, NPM 6, Act. 1)

Through our partners and contractors we will develop an integrated 5 year strategic plan that includes strategies for working towards this goal in partnership with the Child and Adolescent Health Program, the Office of Superintendent of Public Instruction, Family Educator Partnership Project, Division of Developmental Disabilities, Division of Vocational Rehabilitation, and the Office of the Insurance Commissioner. Contractors who will be involved will include the Adolescent Health Transition Project, Washington State Parent to Parent, Washington State Fathers Network, and the Center for Children with Special Needs. Evaluation work may involve developing a baseline for measuring successful transition to adult services in Washington State. (Fig. 4a, NPM 6, Act. 2)

The CSHCN Program will contract with CHRMC to provide analysis of available data to develop additional methods to measure this performance measure on Adolescent Health Transition. (Fig. 4a, NPM 6, Act. 3)

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					
Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	82	82.5	83	75	76.4
Annual Indicator	72.5	71.2	69.2	75.3	75.3
Numerator	57141	56890	54681	61045	
Denominator	78816	79903	79019	81069	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	77	78	79	79	79

Notes - 2002

Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.
Numerator data came from the National Immunization Survey 2001, Centers for Disease Control and Prevention (CDC). This estimate is based on the provider-verified responses for children who live in households with telephones. Statistical methods are used to adjust for children whose parents refuse to participate, those who live in households without telephones, or those whose immunization histories cannot be verified through their providers. The numerator is the estimated number of children with completed immunizations. Denominator data came from the Washington State Office of Financial Management.

Notes - 2003

Numerator data came from the National Immunization Survey 2003, Centers for Disease Control and Prevention (CDC). This estimate is based on the provider-verified responses for children who live in households with telephones. Statistical methods are used to adjust for children whose parents refuse to participate, those who live in households without telephones, or those whose immunization histories cannot be verified through their providers. The numerator is the estimated number of children with completed immunizations. Denominator data came from the Washington State Office of Financial Management. We adjusted the previous year’s data to include only 2 year olds per the detail sheet for this performance measure.

Notes - 2004

Data were unavailable for the year 2004.

Data came from the National Immunization Survey 2003, Centers for Disease Control and Prevention (CDC). This estimate is based on the provider-verified responses for children who live in households with telephones. Statistical methods are used to adjust for children whose parents refuse to participate, those who live in households without telephones, or those whose immunization histories cannot be verified through their providers. The numerator is the estimated number of children with completed immunizations. Denominator data came from the Washington State Office of Financial Management. We adjusted the previous year’s data to include only 2 year olds per the detail sheet for this performance measure.

PERFORMANCE OBJECTIVES: Future targets were chosen from a combination of Maternal and Child Health staff discussions and trend analyses.

a. Last Year's Accomplishments

The estimated vaccination coverage rate for children in Washington State aged 19 to 35 months for 4:3:1:3:3 according to National Immunization Survey data for 2003 was 75.38 percent (+ 4.6

percent).

The Immunization Program (IP) continued to contract with all 35 LHJs to complete immunization AFIX (assessment, feedback, incentive, and exchange) visits to enrolled private immunization provider sites. In addition, the state continued trainings for LHJs, including AFIX requirements, technical assistance, and phone consultation regarding materials and site visits as needed. (Fig. 4a, NPM 7, Act. 1)

The IP, in partnership with the Asian Pacific Islander (API) task force, implemented adolescent hepatitis B screening, education, and vaccination activities in one high school with high API populations. The API Provider task force has recruited 9 physicians to act as hepatitis B peer educators and has developed algorithms for provider and clinic use. The IP continues to distribute the Perinatal Hepatitis B guidelines with updates to hospitals, providers, and LHJs. (Fig. 4a, NPM 7, Act. 2)

A WIC/IP Record Round-Up Project was implemented June 1, 2004 at eighteen WIC agencies in seventeen counties. In 2004, OMCH implemented new immunization requirements for school entry to include Hepatitis B up through the seventh grade level and a second MMR up through fourth grade. (Fig. 4a, NPM 7, Act. 3)

The IP completed project contracts with two Washington tribes who entered immunization information for all their children into the Immunization Registry. The IP continued to strengthen partnerships with the tribes. The IP was invited, along with a number of federal and state agencies, to attend a Tribal Long Range Planning Summit. (Fig. 4a, NPM 7, Act. 5)

As of September 30, 2004, the CHILD Profile System sent 406,538 well-child checkup and immunization reminders, as well as other parenting information, to parents of children 0 to 6 years of age. (Fig. 4a, NPM 7, Act. 6)

Additionally, in June of 2004, CHILD Profile Health Promotion reached full statewide expansion of the Health Promotion system. The percentage of children 19 to 35 months of age with complete immunizations in the system increased to 23.8 percent, compared to 16 percent in 2003. Implementation of the provider recruitment plan resulted in 48 percent of providers agreeing to participate in the registry, up from 19 percent in 2003. (Fig. 4a, NPM 7, Act. 7)

CHILD Profile and the WIC Program continued plans to develop a linkage between the WIC Client Information Management System (CIMS) and the CHILD Profile Immunization Registry. This linkage will help to facilitate the USDA requirement for WIC to screen DTaPs for children 0 to 2 years of age.

All local public health agencies have contracts with the Immunization Program in the Office of Maternal and Child Health. They work with local providers to assure proper use and storage, and several administer vaccinations directly to community members.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Contract with LHJs and others to complete immunization AFIX visits to enrolled private provider sites.				X
2. Contract with Community/Migrant Health Centers to enhance utilization of the Washington State Immunization registry in clinic practice.			X	
3. Fund a collaborative statewide WIC/IP workgroup and Immunization				X

Record Roundup Project in selected counties.				
4. Partner with LHJs to conduct population-based surveys to assess immunization levels of two year old children.				X
5. Contract with federally recognized tribes to help build capacity to assess immunization coverage rates.				X
6. Send parents age-specific reminders of the need for well-child checkups and immunizations via CHILD Profile Health Promotion.		X		
7. Maintain and increase the number of health care providers participating in the CHILD Profile Immunization Registry to improve access to historical records and use the system's immunization recommendation schedule.				X
8.				
9.				
10.				

b. Current Activities

The IP continues to contract with LHJs to complete AFIX site visits on at least 20 percent of all enrolled immunization provider sites in the state. Training for staff and technical assistance will be provided as needed. Data regarding provider immunization coverage rate changes will be shared with LHJs. The IP will also begin strategic planning for AFIX site visits, including increased use of the CHILD Profile Immunization Registry. (Fig. 4a, NPM 7, Act. 1)

In the fall of 2004, the IP co-hosted an information table at the Washington State Tribal Leader Health Summit. The IP continues to build partnerships with the tribes and provide funding for tribes to participate in projects to enhance vaccination coverage rates of native populations within the state. (Fig. 4a, NPM 7, Act. 5)

The IP continues to promote the reporting of perinatal hepatitis B by providers in order to increase the number of HBsAg+ women who are reported for follow-up. The Perinatal Hepatitis B Prevention Program surveillance showed that infants born to HBsAg+ women increased by 23% from 2002 to 2003. Through education, outreach, and strengthening of the Perinatal Hepatitis B Program, the number of infants born to HBsAg+ women completing the three dose hepatitis series by 12 months of age increased to 88 percent. The IP is working with the Maternal Infant Health (MIH) Program to reinforce hepatitis B immunization during pregnancy. Messages directed toward prenatal care providers have been published in the Washington ACOG newsletter and the "Nine Months to Get Ready" booklet. The IP is working with MIH to reinforce screening of pregnant women and reporting of HBsAg+ women. (Fig. 4a, NPM 7, Act. 2)

The IP has worked with the State Board of Health to adopt changes to the notifiable conditions rules to assure that LHJs receive consistent reporting on all cases of hepatitis B.

The WIC/IP Planning Workgroup will begin development of the 2006-2010 WIC/Immunization Linkage Activities Strategic Plan. Tribes that have WIC Programs will be offered an opportunity to participate in the 2005 WIC/IP Record Round-Up Project beginning July 1, 2005. In September 2005, OMCH will implement new immunization requirements for school entry to include hepatitis B up to the ninth grade level and a second MMR through the twelfth grade level. (Fig. 4a, NPM 7, Act. 3)

CHILD Profile and the WIC Program will continue developing a linkage between the WIC/CIMS and the CHILD Profile Immunization Registry. This linkage will help meet the USDA requirement for WIC to screen DTaPs for children 0 to 2 years of age. As of January 31, 2005, parents of 407,767 children 0 to 6 years of age were sent reminders of the need for well-child checkups, immunizations, and other important parenting information. (Fig. 4a, NPM 7, Act. 6)

Continued implementation of the provider recruitment plan resulted in 51 percent of providers

agreeing to participate in the registry, up from 34 percent in 2004. (Fig. 4a, NPM 7, Act. 7)

c. Plan for the Coming Year

The IP will continue to contract with the LHJs to complete AFIX site visits on at least 20 percent of all enrolled immunization provider sites in Washington state. Training for new staff and technical assistance will be provided as needed. Data regarding provider immunization cover rate changes will be shared with LHJs. The IP will continue strategic planning for VFC/AFIX site visits, including increased use of the CHILD Profile Registry. (Fig. 4a, NPM 7, Act. 1)

The IP will conduct high school education, screening, and vaccination for hepatitis B in 1 to 2 high schools with API populations of 25 percent or more. Immunization best practices for juvenile correction centers will be developed by the end of year 2005. A pilot for best practices will be developed and implemented in 2006. The Perinatal Hepatitis B Prevention Program will continue to be supported.

CHILD Profile and the WIC program continue to work towards linkage of the CIMS and the CHILD Profile Immunization Registry. This linkage will help to facilitate the USDA requirement for WIC to screen DTaPs for children 0 to 2 years of age. Pilot projects are expected to be selected by middle of 2006. Additionally, OMCH will be implementing new immunization requirements for school entry to include hepatitis B up to the eighth grade level and a second MMR up to the fifth grade.

The IP plans to continue funding for interested Washington tribes to participate in projects that include activities to enhance vaccination coverage rates of native populations within the state. (Fig. 4a, NPM 7, Act. 5)

In 2006, CHILD Profile Health Promotion will continue working towards increasing the number of parents of children aged 0 - 6 years of age who are sent reminders of the need for well-child checkups and immunizations. (Fig. 4a, NPM 7, Act. 6)

Continued implementation of the CHILD Profile provider recruitment plan should result in 665 (71 percent) private provider sites and 181 (91%) public sites participating in the Immunization Registry. The statewide expansion goal for the Immunization Registry is to have 95 percent of providers participating by the end of 2006. (Fig. 4a, NPM 7, Act. 7)

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	23.8	23	22.2	16.5	16.1
Annual Indicator	20.4	17.7	16.8	15.3	15.3
Numerator	2559	2251	2151	1976	
Denominator	125235	127203	128193	128868	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance	14	14	14	14	14

Objective					

Notes - 2002

The rate of births (per 1,000) for teenagers ages 15-17 years.
The source of these data is the Washington Center for Health Statistics Birth Certificate files (updated annually between September and October). The numerator is defined as the number of live births to women ages 15-17. The denominator is the estimate of 15-17 year old women in Washington on April 1, 2001, from Office of Financial Management. Missing data are excluded. Less than 1% of the age data are missing.

Notes - 2003

The source of these data is the Washington Center for Health Statistics Birth Certificate files (updated annually between September and October). The numerator is defined as the number of live births to women ages 15-17. The denominator is the estimate of 15-17 year old women for the year 2003 in Washington on February 2005, from Office of Financial Management. Missing data are excluded. Less than 1% of the age data are missing.

Notes - 2004

Data were currently unavailable for 2004.

PERFORMANCE OBJECTIVES: Future targets were chosen from a combination of Maternal and Child Health staff discussions and trend analyses.

a. Last Year's Accomplishments

Abstinence Education: OMCH applied a two-pronged media-based approach towards abstinence education: (1) a statewide public awareness campaign and (2) a media literacy curriculum. By gaining insight from other states and by identifying best practices around abstinence education funding, OMCH laid the foundation for a statewide public awareness campaign addressing abstinence and benefits of delaying sexual activity. Focus groups were conducted with parents of young teens and youth ages 10 through 14 in various locations throughout the state. The purpose of these focus groups was to gather reactions on existing media messages in addition to collecting data on knowledge, attitudes, and beliefs around abstinence, sexual activity, and positive youth development. The final results from the focus groups informed the development of the campaign, which began in April 2005. The campaign includes television ads, radio ads, billboards, and cinema screen ads. Simultaneously, a media literacy curriculum was also developed that enables middle-school aged youth to deconstruct media messages related to sexual activity. The curriculum was piloted in 5 sites throughout Washington and was taught by youth leaders in those sites. The pilot sites underwent thorough evaluation in order to determine efficacy and cause for future implementation. (Fig. 4a, NPM 8, Act. 1 and 2)

Youth Development Program: OMCH put forward a Request for Proposal (RFP) seeking community-based intervention projects that decrease the incidence of teen pregnancy among youth who are at higher risk in selected communities. A secondary goal is to eliminate health disparities in communities with high rates of teen pregnancy. Due to limited funding, only 3 sites were selected to implement community-based interventions with a family planning component. The start date for these projects was August 1, 2004 and will be funded for an initial period of 12 months. Concurrent evaluation and monitoring of these sites will determine effectiveness. (Fig. 4a, NPM 8, Act. 3)

Local efforts to reduce teenage birth rates include: Participating on local Teen Pregnancy Prevention Task Forces; developing media stories and links to publicize the situations in their communities; conducting an assessment of teen pregnancy from 1980 -- 2001; and providing family planning services to improve access in a small community. (Fig. 4a, NPM 8, Act. 3)

Many LHJs provide direct service or referral for pregnancy testing and family planning. Efforts to increase time between pregnancies and intendedness of pregnancy among teen parents include supporting an area-wide Teen Parent Advisory Committee, and family planning classes included at

the Teen Parent Program.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collect data to inform the development of statewide public awareness campaign regarding Abstinence Education (Ab-Ed) targeting youth ages 10 – 14 years and parents.			X	
2. Develop, pilot, and evaluate Ab-Ed-based media literacy curriculum for youth at 5 sites.		X		
3. Select, fund, and evaluate 3 – 5 sites for the teen pregnancy prevention project that incorporates community-based interventions with a family planning component.	X			
4. Implement and monitor the Ab-Ed-based statewide public awareness campaign targeting youth and parents.			X	
5. Expand use of the media literacy curriculum for youth to other sites and continue evaluation.		X		
6. Continue funding and evaluating sites for teen pregnancy prevention projects contingent on funding and satisfactory work.	X			
7.				
8.				
9.				
10.				

b. Current Activities

Abstinence Education: OMCH launched the statewide public awareness campaign in April 2005. A media firm was competitively selected to strategize, develop, and implement the campaign. The focus groups results from 2004 form the foundation for the campaign. Similarly, the media literacy curriculum is being extended to other communities, given successful evaluation results from pilot sites. Evaluation and monitoring of new sites is being continued to ascertain effectiveness. (Fig. 4a, NPM 8, Act. 1, 4, and 5)

Youth Development Program: Three teen pregnancy prevention project sites are implementing community-based interventions with a family planning component. Sites may be awarded additional funding only after successful completion of the initial 12-month project period. Evaluation and monitoring is being sustained on an annual basis. (Fig. 4a, NPM 8, Act. 3, 6)

c. Plan for the Coming Year

Abstinence Education: OMCH will continue to refine and implement the statewide public awareness campaign targeting younger youth and parents, as determined by post-campaign evaluation results. The same media firm that developed the original campaign will be recruited for this next phase. Similarly, the media literacy curriculum will be extended to at least 9 communities statewide, given successful evaluation results from pilot sites. Evaluation and monitoring of new sites will be continued to ascertain effectiveness. (Fig. 4a, NPM 8, Act. 4, 5)

Youth Development Program: Contingent on funding, the 3 teen pregnancy prevention project sites will continue to implement community-based interventions with a family planning component, as they are near completion of their initial 12-month project period. Due to limited funding, other sites may not

be selected. Evaluation and monitoring will be sustained on an annual basis. (Fig. 4a, NPM 8, Act. 6)

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	48.2	48.6	48.9	49.3	49.6
Annual Indicator	55.5	55.5	55.5	55.5	55.5
Numerator	50993	50993	45800	46009	
Denominator	91938	91938	82570	82900	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	55.5	55.5	55.5	55.5	55.5

Notes - 2002

Percent of third graders with sealants.
These data were obtained from the Smile Survey 2000. The percent of third grade children who have received protective sealants on at least one permanent molar tooth is 55.5 (95% Confidence Interval is 52.7-58.3). For this survey, an electronic list of all public elementary schools in Washington was obtained from the Office of Superintendent of Public Instruction. Fifty-five schools with at least 25 children in second and/or third grade were randomly selected for participation. Seven of the schools refused to participate resulting in 48 schools with an enrollment of 6,814 children in second and third grade. Of the total 2,699 children who participated, 1,217 were in third grade. Schools who participated were more likely to have a low-income student body, and students who participated were also more likely to be low income. The children taking part in this survey are not representative of the state as a whole, since both minority children and low-income children were over-sampled. Since income has been shown to be related to sealant use, this estimate may underestimate the true percentage of third graders with at least one sealant on a permanent molar tooth. The denominator is the estimated number of 8 year-old children in 2000 reported by the Office of Financial Management, 2002.

Notes - 2003

The Smile Survey is currently being conducted, with results pending.

These data were obtained from the Smile Survey 2000. The percent of third grade children who have received protective sealants on at least one permanent molar tooth is 55.5 (95% Confidence Interval is 52.7-58.3). For this survey, an electronic list of all public elementary schools in Washington was obtained from the Office of Superintendent of Public Instruction. Fifty-five schools with at least 25 children in second and/or third grade were randomly selected for participation. Seven of the schools refused to participate resulting in 48 schools with an enrollment of 6,814 children in second and third grade. Of the total 2,699 children who participated, 1,217 were in third grade. Schools who participated were more likely to have a low-income student body, and students who participated were also more likely to be low income. The children taking part in this survey are not representative of the state as a whole, since both minority children and low-income children were over-sampled. Since income has been shown to be related to sealant use, this estimate may underestimate the true

percentage of third graders with at least one sealant on a permanent molar tooth. The denominator is the estimated number of 8 year-old children in 2000 reported by the Office of Financial Management, 2002.

Notes - 2004

The Smile Survey is currently being conducted, with results pending. New data were unavailable at this time.

PERFORMANCE OBJECTIVES: Future targets were chosen from a combination of Maternal and Child Health staff discussions and trend analyses.

a. Last Year's Accomplishments

Training and technical assistance support was provided to LHJs as they refined local oral health programs to benefit MCH populations. LHJ training and professional development events occurred in a November 2003 multi-day retreat and a May 2004 single-day event. LHJs were actively involved in local sealant programs. LHJ's submitted oral health plans for the 2005-2006 consolidated contract cycle in fall 2004. (Fig. 4a, NPM 9, Act. 3)

Smile Survey planning continued, involving primarily OMCH Assessment staff, Oral Health staff, OSPI, and a consultant oral health epidemiologist. (Fig. 4a, NPM 9, Act. 1)

OMCH continued its support for and involvement with the Washington State Oral Health Coalition and other activities that promote oral health for low-income children. Further collaboration occurred with DSHS, MAA on the Medicaid sealant services and ABCD programs; DOH, Office of Drinking Water and Washington State Dental Association (WSDA) on water fluoridation issues; and the Washington Dental Services Foundation on developing dental training for pediatricians and other medical personnel.

Local agencies used state and MCHBG funds to support oral health in a number of ways. Examples are: support to their area's ABCD program, support for screening in their ABCD program, participation on local dental coalitions, development of a dental access plan as part of the Community Health Center federal application, development of dental care services for 0 -- 18 year olds through grassroots community organizations, and provision of training to local primary care physicians that resulted in making oral health a part of each well child visit.

OMCH applied for and was awarded a federal HRSA State Oral Health Collaborative Systems (SOHCS) grant in September 2003 to implement recommendations from the State Oral Health Summit of October 2002. This grant funded a contract with the University of Washington, School of Dentistry for expert assistance in developing the oral health component of the state adolescent health services plan, and facilitation of an interagency effort among DOH, DSHS, and OSPI to identify early intervention opportunities for children's oral health.

OMCH and DOH Health Systems Quality Assurance Division began the process for review and reporting on the implementation of the Substitute Senate Bill 6020 that created a school-based sealant and varnish program. OMCH sent out a survey to LHJ's to gather baseline data on implementation. (Fig. 4a, NPM 9, Act. 4)

WIC and First Steps visits are opportunities used to demonstrate good oral health care for infants, children and women. A sample of how local agencies used MCH funds to increase oral health is providing preschool and parent training using the "Cavity-free Kids" curriculum; both 2nd and 3rd graders were provided with sealants, providing varnishes to all children in Head Start; and distributing oral health toolkits at health fairs and other community events.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collect, analyze, and disseminate results of the Smile Survey, which looks at the oral health status of children in the state through a randomized sampling process.				X
2. Review Medicaid and ABCD data on provision of sealants through annual consultation with DSHS, MAA.				X
3. Offer Oral Health funding to all LHJs through MCH consolidated contracts; LHJ activities may include support for, and referral to, sealant programs.		X		
4. Monitor and review the implementation of SSB 6020, which created school-based sealant and fluoride varnish oral health programs.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In October 2004, Smile Survey screeners were trained and calibrated, and LHJs were trained to use the "Epi-Info" oral health software for data recording. In 2005, Smile Survey data is being collected in elementary schools and child care/child development centers. One element of the survey is sealants on molars in third graders. The Smile Survey data will be analyzed and a report published by the end of 2005. Data from Medicaid, ABCD programs, and other sources will be compiled and analyzed to gain a better understanding of access issues in the state. (Fig. 4a, NPM 9, Act. 1)

Existing community and organizational partnerships are being maintained and strengthened, and new ones created, so that oral health programs are extended to the underserved. Concentrated efforts are devoted to optimize and sustain the working partnerships with the UW School of Dentistry, the Washington Dental Services Foundation, and the Washington State Dental Association.

Oral health funding is included in the 2005-2006 consolidated contracts to all LHJs. Training is being provided to LHJs. OMCH and HSQA are continuing the process of monitoring and reviewing the implementation of SSB 6020. School-based sealant activities and services provided under SSB 6020 will be documented in a report to the Washington State Legislature by December 2005. (Fig. 4a, NPM 9, Act. 3)

OMCH continues to contract with the University of Washington School of Dentistry for expert assistance in developing the oral health component of the state adolescent health plan. UW also continues to facilitate an interagency effort among DOH, DSHS, and OSPI to identify early intervention opportunities for children's oral health.

In September 2004, OMCH again received a HRSA SOHCS grant. We anticipate that this funding will continue until August 2007.This year, the focus is on analysis of the 2005 Smile Survey; development of an OMCH Oral Health Strategic Plan; design of an evaluation plan, including logic model and key indicators for the Strategic Plan; and proposing oral health indicators for other DOH health assessment instruments.

In January 2005, OMCH hired a dentist with both an MPH and an MBA to manage the oral health program.

c. Plan for the Coming Year

The Smile Survey data will be analyzed and a report published by the end of the 2005. Other more frequent surveillance strategies will be explored and undertaken to determine sealant use.

OMCH and HSQA will complete the review of the implementation of SSB 6020. OMCH will submit a report to HSQA, which is responsible for the final report to the legislature in December 2005. The findings will be analyzed to determine any changes needed to make the outreach more effective.

Under the continuing SOHCS grant, we intend to implement the OMCH Oral Health Strategic Plan and incorporate this into LHJ oral health activity plans, disseminate the completed OMCH Oral Health Strategic Plan to key stakeholders, and implement evaluation of the OMCH Oral Health Strategic Plan.

Continue to compile and analyze data from Medicaid, ABCD programs, and other sources to gain a better understanding of access issues in the state and to determine underserved populations. (Fig. 4a, NPM 9, Act. 1)

One staff from the Oral Health Program will be assigned as the state sealant coordinator. The coordinator's role will be to promote and coordinate sealant programs around the state.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	3	3	3	2.9	2.9
Annual Indicator	3.4	2.8	2.7	2.9	2.9
Numerator	43	35	34	37	
Denominator	1255051	1258895	1260062	1256446	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	2.5	2.4	2.3	2.2	2.1

Notes - 2002

The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children
The source of the data is the Washington State Center for Health Statistics Death Certificate Files (updated annually between September and October). The numerator is defined as the number of Motor Vehicle Crash (MVC) deaths occurring to children aged 0-14 years. The denominator is the estimate number of children 0-14 years old in 2001 in Washington from the Office of Financial Management. The numerator data represent unintentional motor vehicle traffic-related deaths with the following ICD-10 codes: ICD-10 codes: V30-39(.4-.9), V40-49(.4-.9), V50-59(.4-.9), V60-69(.4-.9), V70-79(.4-.9), V81.1,V82.1,V83-V86 (.0-.3), V20-28(.3-.9), V29 (.4-.9), V12-14 (.3-.9), V19(.4-.6), V02-04(.1-.9),V09.2,V80(.3-.5),V87(.0-.8),V89.2. 1998 and 1999 data werew chanegd to reflect these

codes.

Notes - 2003

The source of the data is the Washington State Center for Health Statistics Death Certificate Files (updated annually between September and October). The numerator is defined as the number of Motor Vehicle Crash (MVC) deaths occurring to children aged 0-14 years. The denominator is the estimate number of children 0-14 years old in 2003 in Washington from the Office of Financial Management. The numerator data represent unintentional motor vehicle traffic-related deaths with the following ICD-10 codes: ICD-10 codes: V30-39(.4-.9), V40-49(.4-.9), V50-59(.4-.9), V60-69(.4-.9), V70-79(.4-.9), V81.1,V82.1,V83-V86 (.0-.3), V20-28(.3-.9), V29 (.4-.9), V12-14 (.3-.9), V19(.4-.6), V02-04(.1-.9),V09.2,V80(.3-.5),V87(.0-.8),V89.2.

Notes - 2004

Data were currently unavailable for 2004.

PERFORMANCE OBJECTIVES: Future targets were chosen from a combination of Maternal and Child Health staff discussions and trend analyses.

a. Last Year's Accomplishments

Due to Washington State's financial crisis, state funding that supports the Child Death Review (CDR) program was eliminated from the state budget. CDR is a community process that reviews information about unexpected deaths of children, such as motor vehicle crash deaths, in order to make prevention recommendations. Twenty of the 30 LHJs that had CDR teams continued to do some CDR work even without state funding. (Fig. 4a, NPM 10, Act. 3)

OMCH continues to maintain the CDR web-based reporting system and provides limited technical assistance for local teams.

OMCH worked collaboratively with the Injury Prevention program at DOH to produce a report entitled "Childhood Injury in Washington State" (September 2004), which includes information on motor vehicle crashes (MVC) and recommendations on preventing deaths due to MVC. (Fig. 4a, NPM 10, Act. 6)
(http://www.doh.wa.gov/cfh/injury/pubs/childhood_injury_report.htm)

A number of local health jurisdictions used MCH Block Grant funds to focus on car seat safety, including inspections and providing free and reduced-cost car seats. Specific efforts included collaboration with law enforcement, private insurance, and the Hispanic community to provide child passenger safety and education activities; and development of a pregnancy tracking system that includes use of car seats for infants.

OMCH staff will continue to collaborate with the DOH, Injury Prevention Program on activities that are common priorities for both programs. (Fig. 4a, NPM 10, Act. 6)
A dozen LHJs reported that they utilized MCH funds to focus motor vehicle safety with car seat inspections and/or providing free or reduced-cost car seats and other vehicle safety.
Of special interest were these additional activities: San Juan worked with service organizations in their community to supply additional funds to buy car seats, then partnered with EMS to store and install seats properly; Garfield provided 4-wheeler education to adolescents in grades 9 through 12; and Thurston included car seat safety as part of their yearly safety awareness event at the major shopping mall in their community.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Provide parents of children 0 - 6 years with car seat and booster seat information and resources via CHILD Profile Health Promotion Materials.			X	
2. Promote the use of car seats, booster seats, and other motor vehicle safety activities by several LHJs.			X	
3. Review all unexpected deaths (including motor vehicle crashes) of children 0 – 18 to by local CDR teams to identify community prevention strategies.				X
4. Conduct surveillance of motor vehicle crash deaths to children through the CDR process and disseminate aggregate data and/or prevention recommendations.				X
5. Participate in the Harborview Injury Prevention Research Center's 3 year grant (2004 – 2006) to improve the injury prevention capacity of local public health.				X
6. Collaborate with injury prevention programs outside MCH such as Safe Kids State Coalition and DOH cross-divisional Injury Prevention Workgroup.				X
7.				
8.				
9.				
10.				

b. Current Activities

OMCH works with the local CDR teams who are continuing to function. The state database and reporting system continue to be supported. Technical assistance continues to be offered to local teams. (Fig. 4a, NPM 10, Act. 3)

CHILD Profile continues sending car seat, booster seat, and air bag safety information to parents of children 0 -- 6 years of age. Information is refined as statewide data and laws change. (Fig. 4a, NPM 10, Act. 1)

OMCH participates in an advisory committee to the Harborview Injury Prevention Resource Center to support a CDC and Prevention demonstration project with 4 local CDR teams to link regional Emergency Medical Services (EMS) injury prevention coordinators to local teams. Additionally, this project is developing a data analysis and decision-making tool to help CDR teams generate prevention recommendations. (Fig. 4a, NPM 10, Act. 5)

OMCH staff continues to collaborate with the DOH, Injury Prevention Program on activities that are common priorities for both programs. (Fig. 4a, NPM 10, Act. 6)

c. Plan for the Coming Year

OMCH will work with the 20 local CDR teams who are continuing to function. The state database and reporting system will continue to be supported. Technical assistance will continue to be offered to local teams. (Fig. 4a, NPM 10, Act. 3)

CHILD Profile will continue to send car seat, booster seat, and air bag safety information to parents of children 0 -- 6 years of age. Information will be refined as statewide data changes. (Fig. 4a, NPM 10, Act. 1)

OMCH will continue to participate in an advisory committee to the Harborview Injury Prevention Resource Center to support a CDC demonstration project with 4 local CDR teams to link regional EMS injury prevention coordinators to local teams. Additionally, this project will develop a data analysis and decision-making tool to help CDR teams generate prevention recommendations. (Fig. 4a, NPM 10, Act. 5)

OMCH staff will continue to collaborate with the DOH, Injury Prevention Program on activities that are common priorities for both programs. (Fig. 4a, NPM 10, Act. 6)

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	90	90.5	91	91.5	92
Annual Indicator	88.0	90.0	87.0	90.0	90
Numerator	68900	69192	68733	72434	
Denominator	78291	76881	79003	80482	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	89	89	90	90	90

Notes - 2002

The source of these data is the 2002 Washington State Pregnancy Risk Assessment Monitoring System (PRAMS). The numerator is based on the estimated proportion of women who reported breastfeeding at any time in PRAMS. The denominator was obtained from the live birth file, for Washington residents.

Notes - 2003

The source of these data is the 2003 Washington State Pregnancy Risk Assessment Monitoring System (PRAMS). The 2003 PRAMS data are delayed at the CDC and were not available for reporting this year. The numerator is based on the estimated proportion of women who reported breastfeeding at any time in PRAMS. The denominator was obtained from the live birth file, for Washington residents.

Notes - 2004

Data were unavailable for 2004.

PERFORMANCE OBJECTIVES: Future targets were chosen from a combination of Maternal and Child Health staff discussions and trend analyses.

a. Last Year's Accomplishments

At one First Steps ABC training, approximately 85 new MSS providers received training in breastfeeding support and teaching techniques. MSS local agency staff provided breastfeeding promotion as part of their health education to about 70 percent of Washington's Medicaid-eligible childbearing aged women, which is about 24,000 women. (Fig. 4a, NPM 11, Act. 1, 2)

The "Perinatal Level of Care Guidelines" (LOC), completed in 2001, recommends lactation support at all hospitals with delivery services. The LOC guidelines are used as a reference by the Certificate of Need program and by hospitals assessing their scope of services.

Certificate of Need program for hospitals inquiring about recommended services including lactation services. The LOC are available on-line, linked to the Washington State DOH website, for use and

dissemination to all interested parties (Fig. 4a, NPM 11, Activity 4).

The revision process for the LOC will begin in 2004. It is anticipated that due to growing evidence of the benefits of breastfeeding for mother and baby, the LOC Guidelines revision will continue to recommend lactation support for all hospitals with delivery services (Fig. 4a, NPM 11, Act. 4).

Initiation and support of breastfeeding is an integral part of services provided to women involved with their local public health providers. Some specific activities included visiting almost 40 percent of postpartum women in the hospital after their deliveries to help them successfully initiate breastfeeding and offer ongoing support and hosting breastfeeding teas which has evolved to development of young mothers not only in mentoring others in breastfeeding, but in parenting skills and parent groups for moms and dads. One LHJ held a contest for breastfeeding moms to write about their experience with prizes of baby items given to "winners". A picture gallery of moms nursing or holding their babies was created for Breastfeeding Awareness Month. Two other LHJs provided a place for nursing mothers to nurse and encouraged acceptance of breastfeeding in the community at their local county fairs and one county loaned breast pumps to nursing mothers, especially college students.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide breastfeeding support and education to low income women on Medicaid through MSS (First Steps).	X			
2. Provide training for MSS providers in breastfeeding support and teaching techniques.		X		
3. Recommend lactation support at all hospitals with delivery services through a Perinatal Level of Care document.				X
4. Collect PRAMS data that measures breastfeeding rates, trends, and disparities between groups.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The First Steps Program expects to train a large number of new MSS staff in breastfeeding promotion and support. Training will emphasize motivational interviewing approaches in client education. MSS providers across the state will continue to provide breastfeeding support and teach low-income pregnant and parenting women. In the redesigned MSS program, breastfeeding promotion is one of the basic health messages that program staff is required to provide each MSS client. The basic health message regarding breastfeeding is included on the standard charting template (in progress) to ensure improved and consistent documentation. (Fig. 4a, NPM 11, Act. 1, 2)

The revision process for the "Perinatal Level of Care Guidelines" began in 2004 and is to be completed in 2005. The Department of Health anticipates that due to growing evidence of the benefits of breastfeeding for mother and baby, the LOC revision will continue to recommend lactation support for all hospitals with delivery services. (Fig. 4a, NPM 11, Act. 3)

PRAMS data continues to be collected and analyzed on breastfeeding initiation rates and duration at one month and two months postpartum. Updates to 2001 and 2002 data are anticipated this year. (Fig. 4a, NPM 11, Act. 4)

A number of counties provided a variety of activities related to increasing the percentage of mothers who breastfeed their infants at hospital discharge including education, outreach, one-on-one support to breastfeeding mothers, pump loans, coalition building in the community, and assessment. Other activities include completing a pilot study of moms who breastfed beyond 2 months postpartum, providing lactation consultation and speaking to childbirth classes about breastfeeding, and lending women breast pumps to support their desire to breastfeed their babies.

c. Plan for the Coming Year

MSS providers will continue to provide breastfeeding support and teach low-income pregnant and parenting women. Breastfeeding promotion will continue as a basic health message required for each MSS client. The basic health message regarding breastfeeding will be included on the standard charting template to ensure improved and consistent documentation. (Fig. 4a, NPM 11, Act. 1, 2)

The 2005 LOC will continue to serve as a guide for hospitals' scope of services and recommend lactation support for all hospitals with delivery services. (Fig. 4a, NPM 11, Act. 3)

PRAMS data will be collected and analyzed on breastfeeding initiation rates and duration at one month and two months postpartum. (Fig. 4a, NPM 11, Act. 4)

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	10	30	50	70	90
Annual Indicator	22.5	40.9	62.2	81.0	85.0
Numerator	18212	32028	47550	59619	67174
Denominator	80981	78310	76458	73649	79028
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	92	94	96	98

Notes - 2002

Percentage of newborns who have been screened for hearing before hospital discharge

In CY 2002, 62.2% of infants born in Washington hospitals received newborn hearing screening (47,550 hospital births in Washington (76,458). In 2002, 27 hospitals screened for the whole year while an additional 15 hospitals included for part of year. The Department of Health is currently piloting newborn hearing tracking and surveillance system with 6 hospitals in the state and plan to implement this statewide in 2004. At that point, information on the number of children with identified

hearing loss will be available. The data presented last year on 2001 was preliminary so we have revised that data.

Notes - 2003

In CY 2003, 81% of infants born in Washington hospitals received newborn hearing screening (59,619 hospital births in Washington (73,649).

Notes - 2004

In CY 2004, 85% of infants born in Washington hospitals received newborn hearing screening.

PERFORMANCE OBJECTIVES: Future targets were chosen from a combination of Maternal and Child Health staff discussions and trend analyses.

a. Last Year's Accomplishments

Early Hearing-loss Detection, Diagnosis, and Intervention (EHDDI) Program staff concluded pilot testing of Phase I of the Tracking and Surveillance System, which focuses on the collection of hearing screening data from hospitals. Beginning in April 2004, staff began adding birthing hospitals to the system at a rate of approximately 5,000 births per month. Phase II of the system is web-based and allows audiologists to access their patients' Phase I data, as well as enter results from diagnostic evaluations of these patients. Phase II was made available to pediatric audiologists from 15 clinics in Washington.

Data gathered by EHDDI Program staff for calendar year 2003 showed that approximately 81% of infants were screened for hearing loss, an increase from 62% in 2002.

The EHDDI Program continued to contract with Children's Hospital and Regional Medical Center to provide technical assistance to hospitals and develop educational materials. The program also continued a contract with MSR Northwest to purchase hearing screening equipment for 19 birthing hospitals in the state that still lacked equipment.

The EHDDI Program partnered with Washington Sensory Disabilities Services (WSDS) and Discoveries to develop an Early Intervention training program for early intervention providers, public health professionals, and parents who work with children who are deaf or hard of hearing. This included a week-long summer training institute for representatives from 9 counties and the Migrant Council. Seven counties and the Migrant Council met criteria to become official pilot areas for ongoing training.

CHILD Profile mailed the Health & Development Record booklet which contains spaces to record the hearing screening received in the hospital and whether the infant passed or was referred for additional screenings. CHILD Profile's 1 month and 3 month letters provided health promotion messages to encourage parents to speak with their health care provider if they have concerns about their child's hearing. Through a partnership with the Infant Toddler Early Intervention Program, CHILD Profile distributed information on hearing milestones in the 3 month, 6 month, and 12 month mailings.

DOH is committed to accomplishing universal newborn hearing screening by establishing a statewide program in the Genetics Section of Maternal and Child Health. LHJs also work with community members, especially hospitals and others who see very young children to ensure that this happens. Some activities included one county that worked with the ICC to improve hearing screening, early detection, and intervention throughout the community. Another met with the head of the hospital's Obstetrics Unit to work out a cooperative system for screening and follow-up. And a third LHJ facilitated the establishment of follow-up procedures for those needing further screening after hospital discharge.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop an EHDDI tracking and surveillance system.				X
2. Conduct annual newborn hearing screening survey with birthing hospitals across the state.				X
3. Contract with CHRMC to promote universal newborn hearing screening in birthing hospitals.			X	
4. Collaborate with Medical Home Resource Teams to promote universal newborn hearing screening and educate Washington State health professionals.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The EHDDI Program continues to add birthing hospitals to Phase I of the Tracking and Surveillance System, anticipating that all hospitals will be on the system by the end of June 2005. Staff analyzed data collected from January-September 2004, and used results to make improvements to the system and protocols. Staff presented data findings at the 2005 National Early Hearing Detection and Intervention meeting in Atlanta, Georgia and to the Washington State Board of Health in April 2005.

Data gathered by EHDDI Program staff for calendar year 2004 project that approximately 88% of infants were screened for hearing loss, an increase from 81percent in 2003.

The EHDDI program maintains contracts with CHRMC to provide technical assistance to birthing hospitals, and with WSDS to provide ongoing early intervention training to pilot areas via interactive videoconferences and on-site coaching.

A second statewide EHDDI Summit will be held in summer 2005, including a variety of professional groups, parents, and members of the deaf community. Participants will evaluate needs across the state and work together to develop solutions.

CHILD Profile is mailing the Health & Development Record booklet which contains spaces to record the hearing screening received in the hospital and whether the infant passed or was referred for additional screenings. CHILD Profile provides health promotion messages in both the 1 month and 3 month letters to encourage parents to speak with their health care provider if they have concerns about their child's hearing. CHILD Profile is partnering with the Infant Toddler Early Intervention Program to distribute information on hearing milestones in the 3 month, 6 month, and 12 month mailings.

c. Plan for the Coming Year

The EHDDI Program will analyze data from Phase I and Phase II of the Tracking and Surveillance system to make further improvements. Staff will also conduct a parent survey to evaluate cultural competency of services accessed, as well as reasons why recommended services were not accessed. Via the contract with WSDS, early intervention provider training will be expanded to additional counties. The EHDDI Program will continue to contract with CHRMC to provide technical

assistance to hospital Universal Newborn Hearing Screening Programs.

CHILD Profile will continue mailing the Health & Development Record booklet which contains spaces to record the hearing screening received in the hospital and whether the infant passed or was referred for additional screenings. CHILD Profile will also continue providing health promotion messages in both the 1 month and 3 month letters to encourage parents to speak with their health care provider if they have concerns about their child's hearing. CHILD Profile will maintain the partnership with the Infant Toddler Early Intervention Program to distribute information on hearing milestones in the 3 month, 6 month, and 12 month mailings.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	6.6	6.5	6.4	6.3	6.2
Annual Indicator	5.5	5.5	4.5	4.5	6.0
Numerator	83925	83925	73077	73077	98000
Denominator	1525907	1525907	1623925	1623925	1638000
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5	5	5	5	5

Notes - 2002

The percent of children without health insurance.
The data source is the 2002 Washington State Population Survey, from the Washington State Office of Financial Management (OFM). The State Population Survey is a telephone-based survey that takes place every two years. Children include persons 0 through age 18. Insurance status was based on time of interview. Estimates are adjusted for missing income or insurance status data.

Notes - 2003

No new data for 2003.
The data source is the 2002 Washington State Population Survey, from the Washington State Office of Financial Management (OFM). The State Population Survey is a telephone-based survey that takes place every two years. Children include persons 0 through age 18. Insurance status was based on time of interview. Estimates are adjusted for missing income or insurance status data.

Notes - 2004

The data source is the 2004 Washington State Population Survey, from the Washington State Office of Financial Management (OFM). The State Population Survey is a telephone-based survey that takes place every two years. Children include persons 0 through age 18. Insurance status was based on time of interview. Estimates are adjusted for missing income or insurance status data.

PERFORMANCE OBJECTIVES: Future targets were chosen from a combination of Maternal and Child Health staff discussions and trend analyses.

a. Last Year's Accomplishments

CAH coordinated with other key organizations and agencies to assure children, teens, and their

families had access to health care services, especially health insurance. (Fig. 4a, NPM 13, Act. 2)

CHILD Profile inserted the Healthy Kids Now flyer through collaboration with the Health Improvement Partnership. The target population for this flyer was the 4 - 6 year age group. The Healthy Kids Now insert provided information on how to access free or low-cost health insurance for children. Dissemination of this flyer through CHILD Profile was responsible for 19 percent of total calls received by their hotline, an average of 285 per month. (Fig. 4a, NPM 13, Act. 1)

CHILD Profile health promotion letters referred parents to Healthy Mothers, Healthy Babies to assist them in obtaining medical insurance for their children. (Fig. 4a, NPM 13, Act. 1)

Local efforts to better address the percent of children without health insurance included using assessment data to study insurance status, and providing free services to a limited number of uninsured clients.

LHJ staff assist clients to apply for public insurance and help them work with insurers to improve clients' access to health insurance and care coordination with providers. For example, a public health social worker obtained Statewide Health Insurance Benefits Advisors (SHIBA) training through the Office of the Insurance Commissioner; and the LHJ assisted 2,930 families with Basic Health applications as well as applications for charity care, food assistance, and prescription assistance programs.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide parents of children 0 – 6 years with information about how to access health care via the CHILD Profile Health Promotion Materials.			X	
2. Participate on committees addressing children's access to health care.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CAH continues to coordinate with other key organizations and agencies to assure children, teens, and their families have access to health care services, especially health insurance. This includes developing a plan to address CAH's long-term role in addressing this issue. (Fig. 4a, NPM 13, Act. 2)

CHILD Profile continues to disseminate the Healthy Kids Now insert in the health promotion mailings to provide parents with information on how to access free or low-cost health insurance for children. CHILD Profile health promotion letters continue to refer parents to Healthy Mothers, Healthy Babies to assist them in obtaining medical insurance for their children. (Fig. 4a, NPM 13, Act. 1)

c. Plan for the Coming Year

CAH will continue to coordinate with other key organizations and agencies to assure children, teens, and their families have access to health care services, especially health insurance. This will include administering a contract to support the implementation and evaluation of a program designed to increase children's access to health insurance, i.e. Kids Get Care. (Fig. 4a, NPM 13, Act. 2)

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	90	89.5	90	90.5	91
Annual Indicator	93.5	67.4	91.4	88.9	88.9
Numerator	444845	242365	587057	605669	
Denominator	475567	359757	642455	681060	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	90	90	90	90

Notes - 2002

The source of these data is the Washington State Department of Social and Health Services. The numerator represents the unduplicated count of Medicaid fee-for-service clients under age 19 and below the 200% FPL who had an encounter with a Medicaid provider in 2001. The denominator represents the total number of Medicaid fee-for-service clients under age 19 and below the 200% FPL in 2001. These children may have received Medicaid coverage for any amount of time. In the past we have endeavoured to gather encounter data on children in managed care plans, as well, however the data have been difficult to obtain and largely incomplete.

Notes - 2003

Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

2003 Indicator - 88.9%
Numerator - 605669
Denominator - 681060

Technical Note: The source of these data is the Client Services Database (CSDB), Research Data and Analysis, Washington State Department of Social and Health Services; and Office of Financial Management (OFM). The numerator represents clients aged 1 to 21 years who are receiving medical assistance (Note: Clients receiving medical assistance in SFY 2003 included 20,974 who were not designated as Medically Eligible under Title XIX at some point during the years. The data in the denominator are the total number of medically eligible clients aged 1 to 21 years old.

Notes - 2004

Data were unavailable for 2004.

PERFORMANCE OBJECTIVES: Future targets were chosen from a combination of Maternal and Child Health staff discussions and trend analyses.

a. Last Year's Accomplishments

HMHB implemented a new data system that will allow better tracking of referrals and information provided to callers allowing us to better track the number of families referred for Medicaid or a Medicaid covered service. (Fig. 4a, NPM 14, Act. 1)

MSS continued to serve Medicaid-eligible pregnant women and their families throughout the state. Revisions to the program were implemented October 1, 2003 to improve quality of care and contain costs. Revisions include requirements for basic health messages and referrals for prenatal and child health medical care. (Fig. 4a, NPM 14, Act. 2)

Referrals and assistance linking Medicaid eligibility and needed medical care were routinely provided through contracts with LHJs. (Fig. 4a, NPM 14, Act. 3)

CHILD Profile, MAA, and health plans determined if and how CHILD Profile could help improve rates for Medicaid-eligible children receiving EPSDT screens and immunizations. CHILD Profile health promotion collaborated with MAA to assure that Medicaid-eligible children received reminders of well child check-ups, immunization information, and links to community resources. Every health promotion letter referred parents to HMHB which provides outreach, education, and referrals to families and children searching for health care services. (Fig. 4a, NPM 14, Act. 6)

Calendar year 2004 data was much improved following the modification of the Child Health Intake Form (CHIF) database to screen for incomplete records after January 2004. The modification was completed through contract with Strategic Services. For 2004, information indicated that 70% of the children with special health care needs served by local health jurisdictions had Medicaid coverage. Ninety-four percent of children identified in the database reported an insurance source. This represents an increase of 6% from 2003 data. (Fig. 4a, NPM 14, Act. 5)

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide outreach, education, and referrals through HMHB to families and children and track contacts.			X	
2. Make MSS/ICM provider referrals for newborn and pediatric care.		X		
3. Refer eligible families to Medicaid services through LHJs.		X		
4. ESA and local MSS/ICM providers collaborate to increase identification of Medicaid-eligible women and infants.				X
5. Use CSHCN CHIF data to identify the percent of children in the CSHCN Program with Medicaid coverage.				X
6. CHILD Profile, MAA, and health plans collaborate to improve rates for Medicaid-eligible children receiving EPSDT screening and immunizations.				X
7.				
8.				
9.				
10.				

b. Current Activities

The MSS program continues to review referral systems and work toward improving referrals for pregnant women and infants. Discussions held with DSHS, Economic Services Administration (ESA) have resulted in a proposal to improve communication between local MSS/ICM providers and DSHS,

Community Services Offices (CSOs). (Fig. 4a, NPM 14, Act. 2, 4)

Local health jurisdictions continue to provide referrals and assistance, linking families with Medicaid eligibility and needed medical care. (Fig. 4a, NPM 14, Act. 3)

CHILD Profile, MAA, and health plans are collaborating on how CHILD Profile can help improve rates for Medicaid-eligible children receiving EPSDT screens and immunizations. CHILD Profile health promotion continues to collaborate with MAA to assure that Medicaid-eligible children receive reminders of well child check-ups, immunization information, and links to community resources. CHILD Profile continues to connect parents to HMHB through health promotion letters. (Fig. 4a, NPM 14, Act. 6)

Quality improvement continues to be stressed to meet the standard of 100% reported insurance source for children identified in the CHIF program. Through contract with the CSHCN Program, Strategic Services continues to provide consultation and training to local health jurisdiction partners in order to improve data quality for all data items. Additional training is being provided to CSHCN staff in local health jurisdictions at the 2005 CSHCN Coordinators Conference occurring in late May 2005. Data for 2005 will be included in next year's MCH Block Grant Application. (Fig. 4a, NPM 14, Act. 5)

c. Plan for the Coming Year

The MSS/ICM program will continue to review referral systems and work toward improving referrals for pregnant women and infants. (Fig. 4a, NPM 14, Act. 2)

New positions created within DSHS Regional Offices will work with local communities to ensure that referrals are made to MSS/ICM providers from the CSO system, educate MSS/ICM providers about EPSDT benefits, and facilitate better relationships between MSS/ICM agencies and CSOs. (Fig. 4a, NPM 14, Act. 4)

CHILD Profile, MAA, and health plans continue to collaborate on how CHILD Profile can help improve rates for Medicaid-eligible children receiving EPSDT screening and immunizations. CHILD Profile Health Promotion will continue to collaborate with MAA to assure that Medicaid-eligible children receive reminders of well child check-ups, immunization information, and links to community resources. CHILD Profile will continue to connect parents to HMHB through health promotion letters. (Fig. 4a, NPM 14, Act. 6)

Local health jurisdictions will continue to provide referrals and assistance, linking families with Medicaid eligibility and needed medical care. (Fig. 4a, NPM 14, Act. 3)

Quality improvement will continue to be stressed to meet the standard of 100% reported insurance source for children identified in the CHIF program. (Fig. 4a, NPM 14, Act. 5)

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	0.95	1	1	1	1
Annual Indicator	1.0	1.0	1.0	1.0	1
Numerator	773	825	774	809	

Denominator	80653	79142	77970	80482	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	1	1	1	1	1

Notes - 2002

The percent of very low birth weight live births.
Very low birth weight (VLBW) is defined as any live born infant weighing less than 1500 grams. These data come from the Washington State Center for Health Statistics Birth Certificate Files and are updated annually. The numerator represents the number of resident infants born weighing between less than 1500 grams. The denominator represents all resident live births in the reporting year. Missing data are excluded. 0.5% of the weight data are missing.

Notes - 2003

Very low birth weight (VLBW) is defined as any live born infant weighing less than 1500 grams. These data come from the Washington State Center for Health Statistics Birth Certificate Files and are updated annually. The numerator represents the number of resident infants born weighing between less than 1500 grams. The denominator represents all resident live births in the reporting year. Missing data are excluded. Less than 1% of data are missing.

Notes - 2004

Data were unavailable for 2004.

PERFORMANCE OBJECTIVES: Future targets were chosen from a combination of Maternal and Child Health staff discussions and trend analyses.

a. Last Year's Accomplishments

MSS providers provided nutrition and preventive health education to First Steps clients. Referrals and linkages to WIC are now required under the First Steps redesign. (Fig. 4a, NPM 15, Act. 1, 2, 3)

The MSS performance measure on smoking cessation and pediatric exposure were integrated into the First Steps redesign. (Fig. 4a, NPM 15, Act. 4)

MIH continued to work with MAA to implement the Smoking Cessation benefit for pregnant women, and develop and disseminate provider reference cards to reduce tobacco use by pregnant women. (Fig. 4a, NPM 15, Act. 4)

The Perinatal Regional Centers continued to provide education and consultation to health care professionals providing care to high-risk women and newborns. (Fig. 4a, NPM 15, Act. 5)

The Regional Perinatal Programs continued to monitor the delivery sites of very low birth weight babies and encouraged delivery of these infants in tertiary level facilities. (Fig. 4a, NPM 15, Act. 6)

MIH continued to work with the March of Dimes conducting outreach through the Prematurity Prevention Project. (Fig. 4a, NPM 15, Act. 7)

Local concern for healthy pregnancies resulting in full-term infants led to providing services to families with low birth weight infants including parent education and support; monitoring pregnancy outcomes, especially among American Indian women, and working with local tribal health to develop a comprehensive Maternal and Child Health program for tribal members; and attending the March of Dimes Prematurity Symposium to learn the most current information about premature infants and prevention of premature births.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor prenatal weight gain and provide preventive health education through MSS providers.		X		
2. Increase smoking cessation referrals during pregnancy through MSS Tobacco Initiative.		X		
3. Improve nutrition and weight gain for infants through MSS and Infant Case Management provider referrals to WIC program.		X		
4. Promote the Smoking Cessation benefit for pregnant women through OMCH collaboration with MAA.				X
5. Provide education and consultation to health care professionals in management of very low birthweight infants and high-risk pregnancies through Regional Perinatal Centers.			X	
6. Monitor delivery sites of very low birthweight babies and advocate for delivery of these infants at tertiary care facilities through Perinatal Regional Centers.				X
7. Collaborate with March of Dimes on prematurity prevention campaign.			X	
8. Collaborate with stakeholders to monitor access to obstetric care.				X
9. Provide Motivational Interview training for health care professions to improve client compliance with basic healthy behaviors throughout pregnancy.		X		
10.				

b. Current Activities

MSS providers continue to provide nutrition and preventive health education to First Steps clients through referrals and linkages to WIC. (Fig. 4a, NPM 15, Act. 1, 2, 3)

The MSS performance measure on smoking cessation and pediatric exposure continues as part of First Steps redesign. (Fig. 4a, NPM 15, Act. 4)

Motivational Interviewing training continues with First Steps providers to enhance intervention skills used to support and guide pregnant women who smoke toward smoking cessation. (Fig. 4a, NPM 15, Act. 9)

MIH continues work with MAA implement the Smoking Cessation benefit for pregnant women, and develop and disseminate provider reference cards to reduce tobacco use by pregnant women. (Fig. 4a, NPM 15, Act. 4)

The Regional Perinatal Programs continue to provide education and consultation to health care professionals providing care to high-risk women and newborns. (Fig. 4a, NPM 15, Act. 5)

The Regional Perinatal Programs continue to monitor the delivery sites of very low birth weight babies and encourage delivery of these infants in tertiary level facilities. (Fig. 4a, NPM 15, Act. 6)

MIH continues work with the March of Dimes through the Prematurity Prevention Project. (Fig. 4a, NPM 15, Act. 7)

MIH works with stakeholders to monitor access to obstetric care through the OB Access Project. (Fig. 4a, NPM 15, Act. 8)

c. Plan for the Coming Year

MSS providers will continue to provide nutrition and preventive health education to First Steps clients through referrals and linkages to WIC. (Fig. 4a, NPM 15, Act. 1, 2, 3)

The MSS performance measure on smoking cessation and pediatric exposure will continue as part of First Steps redesign. (Fig. 4a, NPM 15, Act. 4)

Motivational Interviewing training will continue as needed with First Steps providers to enhance intervention skills used to support and guide pregnant women who smoke toward smoking cessation. (Fig. 4a, NPM 15, Act. 9)

MIH will continue to work with MAA to implement the Smoking Cessation benefit for pregnant women, and develop and disseminate provider reference cards to reduce tobacco use by pregnant women. (Fig. 4a, NPM 15, Act. 4)

The Regional Perinatal Programs will continue to provide education and consultation to health care professionals providing care to high-risk women and newborns. (Fig. 4a, NPM 15, Act. 5)

The Regional Perinatal Programs will continue to monitor the delivery sites of very low birth weight babies and encourage delivery of these infants in tertiary level facilities. (Fig. 4a, NPM 15, Act. 6)

MIH will continue working with the March of Dimes Prematurity Prevention Project. (Fig. 4a, NPM 15, Act. 7)

MIH will continue working with stakeholders to monitor access to obstetric care through the OB Access Project. (Fig. 4a, NPM 15, Act. 8)

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	11.8	11.7	11.7	8.5	8.4
Annual Indicator	9.8	8.0	8.7	9.6	9.6
Numerator	42	35	38	42	
Denominator	427968	435035	437828	439282	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	8.9	8.6	8.4	8.2	8

Notes - 2002

The rate (per 100,000) of suicide deaths among youths ages 15-19.
The numerator for this rate is defined as the number deaths with ICD 10 Codes X60-X84 and Y87.0 and U03 for youth ages 15-19. The denominator is the estimated population for ages 15-19. The rate is per 100,000 population. The source for the data is the Washington Center for Health Statistics Death Certificate files (updated annually between September and October) and the Office of

Financial Management, Intercensal and Postcensal Estimates of County Population by Age and Sex.

Notes - 2003

The numerator for this rate is defined as the number deaths with ICD 10 Codes X60-X84 and Y87.0 and U03 for youth ages 15-19. The denominator is the estimated population for ages 15-19. The rate is per 100,000 population. The source for the data is the Washington Center for Health Statistics Death Certificate files (updated annually between September and October) and the Office of Financial Management, Intercensal and Postcensal Estimates of County Population by Age and Sex.

Notes - 2004

Data were unavailable for 2004.

PERFORMANCE OBJECTIVES: Future targets were chosen from a combination of Maternal and Child Health staff discussions and trend analyses.

a. Last Year's Accomplishments

The OMCH collaborated with the Injury Prevention Program and implemented an evaluation of the Youth Suicide Prevention Program (YSPP), which included data from the 2002 Healthy Youth Survey. Other YSPP activities included providing Youth Suicide Prevention Campaign Tool Kit Trainings for youth and adults in school communities, providing technical assistance and support to schools engaged in youth suicide prevention efforts, providing consultation on school-based prevention and crisis response planning and implementation, providing suicide awareness presentations to parent and community groups, maintaining and enhancing the YSPP website, disseminating print material at YSPP sponsored events, and acting as a media contact related to youth suicide prevention and intervention.

OMCH also participated in gatekeeper training by assuring that training was provided throughout the state for adults who work with youth; assisted as needed in the planning, marketing, set-up, and delivery of trainings; maintaining networking mechanisms for youth suicide prevention trainers; providing consultation and technical assistance for trainers to assure quality and performance standards , and maintaining a database of current trainers available in Washington and posting it to the YSPP website.

OMCH participated in community development by developing strategies to promote youth suicide prevention within communities through existing networks and organizations, providing communities with consultation on the development and implementation of youth suicide prevention plans, providing technical assistance and support to communities already engaged in youth suicide prevention efforts, supporting local and statewide efforts to promote early identification of children's mental health issues, and working with key stakeholders to advance youth suicide prevention activities and strategies. (Fig. 4a, NPM 16, Act. 1)

OMCH worked collaboratively with the DOH, Injury Prevention Program to produce a report entitled "Childhood Injury in Washington State." OMCH maintained the state database on childhood deaths. OMCH provided technical assistance for the twenty local Child Death Review teams that were able to continue after state funding of local teams was eliminated. The database continued to list public health activities directed at prevention of youth suicide. (Fig. 4a, NPM 16, Act. 2)

Activities by local health in response to concern about youth suicide included providing gun safety classes at community youth events; providing training for Emergency Medical Technicians and other first responders about how to respond to incidents and to school staff on adolescent suicide issues and behaviors; and, in one county, the LHJ responded to three youth suicides by surveying 250 young people to get ideas for activities and supports that would be useful to teens.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

	Pyramid Level of

Activities	Service			
	DHC	ES	PBS	IB
1. Continue to collaborate with the DOH Office of Injury Prevention to implement and evaluate the Youth Suicide Prevention program.			X	
2. Work with local CDR teams to review all unexpected deaths (including suicides) of children ages 0 – 18 years to identify community prevention strategies.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The OMCH will continue to work with the Injury Prevention Program to implement the Youth Suicide Prevention Program statewide to support reducing the teen suicide rate. Plans are to continue 2004 activities and gain further momentum in raising awareness of the problem of youth suicide, train people who work with youth in the skills for early intervention, and engage communities to address suicide through prevention and early intervention planning and skill building. (Fig. 4a, NPM 16, Act. 1)

The OMCH will assist with evaluating the YSPP program efforts by comparing Healthy Youth Survey data from schools with the program to schools without the program. This will be a focus of the Injury Prevention Program during the last half of 2005. (Fig. 4a, NPM 16, Act. 3)

OMCH continues to maintain the state database on childhood deaths. OMCH provides limited technical assistance for the twenty remaining local Child Death Review Teams. The database continues to list public health activities directed at prevention of youth suicide. (Fig. 4a, NPM 16, Act. 2)

c. Plan for the Coming Year

The OMCH will continue to work with the Injury Prevention Program to implement the YSPP statewide in support reducing the teen suicide rate. Plans are to continue 2005 activities, gain further momentum in raising awareness of the problem of youth suicide, train people who work with youth in the skills for early intervention, and engage communities to address suicide through prevention and early intervention planning and skill building. (Fig. 4a, NPM 16, Act. 1)

The OMCH will assist with evaluating the YSPP program efforts by comparing Healthy Youth Survey data from schools with the program to schools without the program. This will be a focus of the Injury Prevention Program during the last half of 2006. (Fig. 4a, NPM 16, Act. 3)

OMCH will continue to maintain the state database on childhood death and provide limited technical assistance for the remaining local Child Death Review Teams. The database will continue to list public health activities directed at prevention of youth suicide. (Fig. 4a, NPM 16, Act. 2)

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk*

deliveries and neonates.

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	79.4	79.6	79.8	80	80.2
Annual Indicator	73.1	75.4	82.6	83.4	83.4
Numerator	520	582	617	627	
Denominator	711	772	747	752	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	85	86	87	88	88

Notes - 2002

The percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.
The numerator is determined by the number of resident very low birth weight (VLBW) births that occur in-state delivered at a hospital providing perinatal intensive care (level III). The denominator represents the total number of VLBW resident infants born in-state. The source for this data is the Washington Center for Health Statistics Birth Certificate Files (updated annually between September and October). Missing data are excluded. 0.5% of the weight data are missing.

Notes - 2003

The percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.
The numerator is determined by the number of resident very low birth weight (VLBW) births that occur in-state delivered at a hospital providing perinatal intensive care (Level III). The denominator represents the total number of VLBW resident infants born in-state. The source for this data is the Washington Center for Health Statistics Birth Certificate Files (updated annually between September and October). Missing data are excluded. Less than 1% of data are missing.

Notes - 2004

Data were unavailable for 2004.

PERFORMANCE OBJECTIVES: Future targets were chosen from a combination of Maternal and Child Health staff discussions and trend analyses.

a. Last Year's Accomplishments

Regional Perinatal Programs were funded to provide professional education, consultation, and transportation of high-risk pregnant women and neonates. Approximately 900 women were transported to one of four regional perinatal centers for high-risk birth and approximately 700 infants were transported from a community hospital to a regional perinatal center for neonatal intensive care. (Fig. 4a, NPM 17, Act. 2)

Regional Perinatal Programs continue to monitor delivery sites of very low birth weight babies and advocate for delivery of these infants at tertiary care facilities. (Fig. 4a, NPM 17, Act. 1)

Regional Perinatal Programs funding continues in order to provide professional education, consultation, and transportation of high-risk pregnant women and neonates. (Fig. 4a, NPM 17, Act. 2)

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor delivery sites of very low birthweight babies and advocate for delivery of these infants at tertiary care facilities through Regional Perinatal Centers.				X
2. Fund Regional Perinatal Centers to provide professional education, consultation, and transportation of high-risk pregnant women and neonates.		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Regional Perinatal Programs continue to monitor delivery sites of very low birth weight babies and advocate for delivery of these infants at tertiary care facilities. (Fig. 4a, NPM 17, Act. 1)

Regional Perinatal Programs funding continues in order to provide professional education, consultation, and transportation of high-risk pregnant women and neonates. (Fig. 4a, NPM 17, Act. 2)

c. Plan for the Coming Year

Regional Perinatal Programs will continue to monitor delivery sites of very low birth weight babies and advocate for delivery of these infants at tertiary care facilities. (Fig. 4a, NPM 17, Act. 1)

Regional Perinatal Programs funding will continue as is in order to provide professional education, consultation, and transportation of high-risk pregnant women and neonates. (Fig. 4a, NPM 17, Act. 2)

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	85	85.5	86	84.2	85.1
Annual Indicator	82.6	83.2	83.4	81.5	81.5
Numerator	61700	60771	60076	52883	
Denominator	74676	73038	72055	64907	
Is the Data Provisional or Final?				Final	Provisional

	2005	2006	2007	2008	2009
Annual Performance Objective	83	83	83	83	83

Notes - 2002

The percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.
The numerator is the number of resident live births with a reported first prenatal visit before 13 weeks gestation. The denominator is the total number of resident live births. Missing data are excluded. In 2001, 8.2% of the data was missing for this measure. The source for these data is the Washington Center for Health Statistics Birth Certificate Files (updated annually between September and October).

Notes - 2003

The numerator is the number of resident live births with a reported first prenatal visit before 13 weeks gestation. The denominator is the total number of resident live births. Missing data are excluded. In 2003, 8.7% of this data was missing for this measure. The source for these data is the Washington Center for Health Statistics Birth Certificate Files (updated annually between September and October).

In 2003 a new birth certificate form was implemented. It collects some information differently, and caution should be used in interpreting year to year changes from 2002 to 2003. NCHS does not believe the methodology is comparable.

Notes - 2004

Data were unavailable for 2004.

In 2003 a new birth certificate form was implemented. It collects some information differently, and caution should be used in interpreting year to year changes from 2002 to 2003. NCHS does not believe the methodology is comparable.

PERFORMANCE OBJECTIVES: Future targets were chosen from a combination of Maternal and Child Health staff discussions and trend analyses.

a. Last Year's Accomplishments

Medical liability insurance rates increased rapidly and many obstetricians and family physicians no longer provide obstetric care. MIH monitored this situation and its relationship to prenatal care access and availability. (Fig. 4a, NPM 18, Act. 4)

DOH, DSHS, and other stakeholders focused on prenatal care access in the state. MIH scaled back an ambitious OB Access Project, which will still identify and monitor available obstetric access information in Washington; but preparation of a report sharing related information with key stakeholders has been postponed due to loss of personnel and resources. (Fig. 4a, NPM 18, Act. 4)

OMCH contracted with 35 LHJs to provide maternal and child health services, which included routine referral and assistance linking with Medicaid eligibility and needed prenatal care in the first trimester, pregnancy tests, referrals to community providers, and prenatal education to pregnant women not eligible for other prenatal support services. (Fig. 4a, NPM 18, Act. 3)

Prenatal care utilization data was mailed to First Steps providers and was included in the Perinatal Indicators Report and shared with the Perinatal Advisory Committee. (Fig. 4a, NPM 18, Act. 4)

Local efforts to increase first trimester prenatal care included continuing support for the pregnancy information line, providing pregnancy tests, providing referrals to community providers, and providing prenatal education to pregnant women not eligible for other prenatal support services. (Fig. 4a, NPM 18, Act. 3)

The HMHB toll-free information and health care referral line responded to 6,840 calls from pregnant women in 2004. 1,288 (19 percent) of these callers were not in prenatal care. Those callers received 2,259 referrals to services including WIC (990), Pregnancy Medicaid (622), Basic Food (180), Children's Medicaid (151), and others. (Fig. 4a, NPM 18, Act. 1)

Most LHJs provide services to pregnant women through the First Steps Program in this state. Additionally, some also provide pregnancy testing, and for those who are pregnant, enrollment or referral to the community First Steps Program. Examples of local efforts to promote early prenatal care include participating in the "Community Baby Shower" at the Women's Pavilion in Cowlitz County promoting MCH services including First Steps. Another county hosted monthly community provider meetings to address new and upcoming program changes, listen to speakers from the community, and coordinate services to clients. A third county observed a decrease in pregnant women being referred from outside agencies so set a plan to market MCH and First Steps prenatal care. This has resulted in increased referrals of eligible women. Building awareness of the need for early referral will provide more opportunity to deliver preventive health messages and change risky health behaviors.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide outreach and education through HMHB to pregnant women to increase early enrollment in prenatal services.		X		
2. Continue MSS provider referrals to prenatal care if clients are not already enrolled and support women to stay in prenatal care.		X		
3. Continue LHJs provider referrals to prenatal care if clients are not already enrolled and support women to stay in prenatal care.		X		
4. Share prenatal care utilization data with MSS and perinatal providers.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

OMCH continues to contract with 35 LHJs to provide maternal and child health services, which include routine referral and assistance linking with Medicaid eligibility and needed prenatal care. (Fig. 4a, NPM 18, Act. 3)

Prenatal care utilization data will be mailed to First Steps providers and included in the Perinatal Indicators report shared with the Perinatal Advisory Committee. (Fig. 4a, NPM 18, Act. 4)

Based on the OB Access Report to be completed in 2005, MIH will work with DSHS and other stakeholders to monitor access to prenatal care. (Fig. 4a, NPM 18, Act. 4)

The HMHB hot-line continues to refer pregnant women for Medicaid eligibility and link to prenatal providers. (Fig. 4a, NPM 18, Act. 1)

Linkage to prenatal care providers continues to be a required MSS activity. (Fig. 4a, NPM 18, Act. 2)

c. Plan for the Coming Year

OMCH will continue to contract with LHJs to provide maternal and child health services, which include routine referral and assistance linking with Medicaid eligibility and needed prenatal care. (Fig. 4a, NPM 18, Act. 3)

Prenatal care utilization data will be mailed to First Steps providers and included in the Perinatal Indicators report shared with the Perinatal Advisory Committee. (Fig. 4a, NPM 18, Act. 4)

Based on the OB Access Report, MIH will work with DSHS and other stakeholders to monitor access to prenatal care. (Fig. 4a, NPM 18, Act. 4)

HMHB hot-line will continue to refer pregnant women for Medicaid eligibility and link to prenatal providers. (Fig. 4a, NPM 18, Act. 1)

Linkage to prenatal care providers is a required MSS activity. (Fig. 4a, NPM 18, Act. 2)

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *The percent of pregnancies (live births, fetal deaths, abortions) that are unintended.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	47%	44	41	53.9	52.8
Annual Indicator	53.0	53.9	54.6	53.2	53.2
Numerator	56185	56619	57047	56173	
Denominator	106010	105140	104449	105588	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective					

Notes - 2002

THIS SPM WILL BE CONTINUED, AS IS, FOR THE 2005-2009 NEEDS ASSESSMENT. PLEASE SEE THE NEW SPM 1 FOR MORE DETAILS.

The percent of pregnancies that are unintended.
This numerator for this measure is derived from [the estimated percentage of unintended pregnancies from Washington State Pregnancy Risk Assessment Monitoring System (PRAMS) survey *(resident live births + fetal deaths)] + reported resident abortions. The denominator for this measure is the number of resident live births + fetal deaths + reported resident abortions. Birth, Fetal death, and Abortion data are obtained from the Washington State Center for Health Care Statistics Birth, Fetal Death, and Abortion files for 2002. PRAMS 2002 data are used here.

Notes - 2003

The percent of pregnancies that are unintended.

The source for the data is the 2003 Washington State PRAMS. This numerator for this measure is derived from [the estimated percentage of unintended pregnancies from Washington State Pregnancy Risk Assessment Monitoring System (PRAMS) survey *(resident live births + reported resident abortions. The denominator for this measure is the number of resident live births + reported resident abortions. Birth and Abortion data are obtained from the Washington State Center for Health Care Statistics Birth, Fetal Death, and Abortion files for 2003.

Notes - 2004

Data were unavailable for 2004.

a. Last Year's Accomplishments

The Family Planning Performance Measure was integrated into a standardized charting system for documentation as part of the First Steps redesign. (Fig. 4b, SPM 1, Act. 1)

MSS providers were offered updates on family planning information. (Fig. 4b, SPM 1, Act. 2, 3)

In 2004, OMCH's CHILD Profile Program included a message about birth spacing and family planning in CHILD Profile Health Promotion materials. The message was placed in the 30-day postpartum and the 3 month letters being sent to approximately 85% of the annual birth population of approximately 80,000. This activity targeted women of childbearing age who have delivered a baby and reside in Washington State. As of September 30, 2004, more than 1,023,595 health promotion materials have been sent to parents statewide. CHILD Profile and CFH Women's Health Network decided not to develop a postpartum booklet that would have included birth spacing and family planning information. (Fig. 4b, SPM 1, Act. 7)

Reports were shared with First Steps providers showing family planning performance measure progress by agency. (Fig. 4b, SPM 1, Act. 4)

PRAMS data on unintended pregnancy was shared with First Steps providers and incorporated into the on-going Perinatal Indicators report shared with the Perinatal Advisory Committee. (Fig. 4b, SPM 1, Act. 5)

A number of counties used the following strategies to decrease the percent of unintended pregnancies: Conducting ongoing assessment of pregnancy intendedness to guide policy and outreach activities; establishing a Teen Pregnancy Prevention Taskforce; conducting an assessment project that concluded that school-based health clinics had contributed to a decreased teen birth rate; and providing family planning services to increase access.

County Profiles were published and disseminated. (Fig. 4b, SPM 1, Act. 4)

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Increase referrals to family planning services and use of birth control.		X		
2. Provide Family Planning update training to MSS agencies.			X	
3. Promote Medicaid Take Charge Program to increase family planning services for men and women		X		
4. Share progress of family planning performance measure utilization data with MSS providers.				X

5. Collect and reference PRAMS data to measure unintended pregnancy rates, trends, and disparities between groups.				X
6. Include Emergency Contraception information in the medical meeting display to increase provider awareness and promote pre-exposure dissemination.			X	
7. Provide messages about birth spacing and family planning in the CHILD Profile parent education letter.			X	
8. Develop and disseminate a self-assessment tool for preconception providers that includes providing birth control information and methods.				X
9.				
10.				

b. Current Activities

MIH continues to include Emergency Contraception information in its medical meeting display to increase provider awareness and promote pre-exposure dissemination. (Fig. 4b, SPM1, Act. 6)

MSS providers continue to be offered updates on family planning information. (Fig. 4b, SPM 1, Act. 2, 3)

In 2005, OMCH's CHILD Profile continues to include a message about birth spacing and family planning in CHILD Profile Health Promotion materials. The message is placed in the 30-day post partum and the 3 month letters and is sent to at least 85 percent of the annual birth population of approximately 80,000. This activity targets women of childbearing age who have delivered a baby and reside in Washington State. (Fig. 4b, SPM 1, Act. 7)

Reports are shared with First Steps providers showing family planning performance measure progress by agency. (Fig. 4b, SPM 1, Act. 4)

PRAMS data on unintended pregnancy is shared with First Steps providers and incorporated into the ongoing Perinatal Indicators report shared with the Perinatal Advisory Committee. (Fig. 4b, SPM 1, Act. 5)

c. Plan for the Coming Year

OMCH intends to continue this performance measure and related activities through the year 2010.

MIH will continue to include Emergency Contraception information in its medical meeting display to increase provider awareness and promote pre-exposure dissemination. (Fig. 4b, SPM1, Act. 6)

MSS providers will be offered updates on family planning information. (Fig. 4b, SPM 1, Act. 2,3)

OMCH's CHILD Profile program will continue to include a message about birth spacing and family planning in CHILD Profile Health Promotion materials in the 30-day postpartum and the 3 month letters. This activity targets women of childbearing age who have delivered a baby and reside in Washington State. In addition, CHILD Profile will explore the opportunity to insert birth control information in the 30-day postpartum or 3 month mailing through a partnership with Family Planning and Reproductive Health. (Fig. 4b, SPM 1, Act. 7)

Reports will be shared with First Steps providers showing family planning performance measure progress by agency. (Fig. 4b, SPM 1, Act. 4)

PRAMS data on unintended pregnancy will be shared with First Steps providers and incorporated into the ongoing Perinatal Indicators report and shared with the Perinatal Advisory Committee. (Fig.

4b, SPM 1, Act.5)

MIH will develop and disseminate a self-assessment tool for preconception providers that includes birth control information and method provision. (Fig. 4b, SPM 1, Act. 8)

State Performance Measure 2: *The percent of pregnant women abstaining from smoking.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	86.5%	87.5%	88.0%	88.5%	89.0%
Annual Indicator	86.5	87.4	88.0	89.1	89.1
Numerator	66934	67779	67727	70704	
Denominator	77384	77587	76929	79328	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective					

Notes - 2002

THIS SPM WILL BE CONTINUED, AS IS, FOR THE 2005-2009 NEEDS ASSESSMENT. PLEASE SEE THE NEW SPM 2 FOR MORE DETAILS.

The percent of pregnant women abstaining from smoking.
The source for these data is the Washington State Center for Health Statistics Birth Certificate file. The numerator is the number of resident women who reported abstaining from smoking during pregnancy on the birth certificate. The denominator is all resident births in the reporting year. 2.5% of the data were missing in 2001 for this measure and are excluded from the denominator.

Notes - 2003

Data were unavailable for 2004.

The source for these data is the Washington State Center for Health Statistics Birth Certificate file. The numerator is the number of resident women who reported abstaining from smoking during pregnancy on the birth certificate. The denominator is all resident births in the reporting year. 2% of the data were missing in 2003 are excluded from the denominator.

In 2003 a new birth certificate form was implemented. It collects some information differently, and caution should be used in interpreting year to year changes from 2002 to 2003. Specifically, changes in smoking may be due wholly or in part to reporting changes.

Notes - 2004

Data were unavailable for 2004.

In 2003 a new birth certificate form was implemented. It collects some information differently, and caution should be used in interpreting year to year changes from 2002 to 2003. Specifically, changes in smoking may be due wholly or in part to reporting changes.

a. Last Year's Accomplishments

MIH continued to inform providers of the Medicaid benefit through articles in professional newsletters, medical meeting exhibits, and professional websites. Through reports provided by MAA, MIH tracked benefit billing data to evaluate how many providers are billing for the intervention. (Fig. 4b, SPM 2, Act. 2 , 4)

CHILD Profile sent information on smoking cessation and listed the Washington State Tobacco Quitline as a resource to parents of children 0 - 6 years of age. Specifically, CHILD Profile included smoking cessation messages in the SIDS brochure sent at birth, the 1- month postpartum, the 3 month, and the 4.5 year letters. (Fig. 4b, SPM 2, Act. 5)

The MSS smoking cessation performance measure was integrated into a standardized charting system for documentation planned as part of the First Steps redesign. Provider training continued. (Fig. 4b, SPM 2, Act. 1)

MIH, in collaboration with MAA and the DOH Tobacco Prevention and Control Program, implemented a tobacco pilot project for 10 First Steps agencies. This project provides additional motivational interviewing and systems change training, follow-up site visits, and other technical assistance. Training and follow-up was complete June 30, 2004. (Fig. 4b, SPM2, Act. 1)

Many public health nurses attended Tobacco Cessation Training to work with pregnant clients. Local health conducted other tobacco avoidance activities, including screening clients for second hand smoke exposure and making referrals to the Quit Line, developing bulletin boards and promoting articles in local newspapers, and developing tracking systems to use for assessment purposes.

PRAMS data was collected and referenced to measure smoking rates before, during, and after pregnancy; quit rates; relapse rates; third trimester smoking trends; and disparities between groups. (Fig. 4b, SPM 2, Act. 6)

Tobacco cessation for pregnant and parenting women and teens is an integral part of services to clients across the state at public health departments. Many are leaders or participants in their local Tobacco Coalitions. Programs locally are shaped to meet unique needs such as developing bulletin boards which were displayed in the health department and at other community events; extending tobacco cessation information to all maternal and child health clients; establishing a bilingual format to meet the needs of Spanish speaking clients; and presenting "Why pregnant women smoke" to members of the community Tobacco Coalition

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MSS Tobacco Initiative to increase smoking cessation among low income women on Medicaid.			X	
2. Work with MAA to implement the Smoking Cessation benefit for pregnant women. Develop and disseminate provider reference card.			X	
3. Disseminate best practice guide for smoking cessation for medical providers.				X
4. Share tobacco data with MSS and perinatal providers.				X
5. Provide information about, and resources for, smoking cessation to parents of children 0 - 6 years via the CHILD Profile Health Promotion Materials.			X	
6. Collect and reference PRAMS data to measure smoking rates before, during and after pregnancy; quit rates; relapse rates; third trimester smoking				X

trends; and disparities between groups.				
7. Work with TPCP to develop and implement FAX back referral program through the statewide Tobacco Quit Line.				X
8.				
9.				
10.				

b. Current Activities

MIH continues to inform providers of the Medicaid benefit through articles in professional newsletters, medical meeting exhibits, and professional websites. Through reports provided by MAA, MIH is tracking benefit billing data to evaluate how many providers are billing for the intervention. (Fig. 4b, SPM 2, Act. 2 , 4)

CHILD Profile is sending information in the SIDS brochure, mailed at birth, 30 days partum, 3 months, and in the 4.5 year letter on smoking cessation. They also list the Washington State Tobacco Quitline as a smoking cessation resource for parents of children 0-6 years of age. (Fig. 4b, SPM 2, Act. 5)

The MSS smoking cessation performance measure is being integrated into a standardized charting system for documentation planned as part of the First Steps redesign. Provider training continues. (Fig. 4b, SPM 2, Act. 1)

MIH is working with the Tobacco Prevention and Control Program to implement and market the FAX back referral to First Steps agencies and medical providers in spring 2005. MIH is working with March of Dimes and TPCP to stage several events statewide to inform medical providers and their office staff about the fax referral program and the Medicad benefit. Events will take place in June and July 2005. (Fig. 4b, SPM 2, Act. 7)

First Steps agencies are receiving enhanced onsite technical assistance, per their request, in order to strengthen working relationships with county tobacco prevention and control contractors; increase utilization of the state Quit Line; increase their knowledge and skills in client centered tobacco cessation messages for pregnant women; developing new policies that reinforce the value of tobacco cessation and protection against secondhand smoke for both staff and clients. Included with this project is an evaluation plan and results are being compiled to assure quality improvement can be measured over time.

PRAMS data is being collected and referenced to measure smoking rates before, during, and after pregnancy; quit rates; relapse rates; third trimester smoking trends; and disparities between groups. (Fig. 4b, SPM 2, Act. 6)

c. Plan for the Coming Year

OMCH intends to continue this performance measure and related activities through the year 2010.

MIH will continue to inform providers of the Medicaid benefit through articles in professional newsletters, medical meeting exhibits, and professional websites. Through reports provided by MAA, MIH will track benefit billing data to evaluate how many providers are billing for the intervention. (Fig. 4b, SPM 2, Act. 2 , 3)

CHILD Profile will continue sending information on smoking cessation and the Washington State Tobacco Quitline resource to parents of children 0 - 6 years of age in their SIDS brochure sent at birth, 1month, 3 month, and the 4.5 year letters. (Fig. 4b, SPM 2, Act. 5)

The MSS smoking cessation performance measure will be integrated into a standardized charting

system for documentation planned as part of the First Steps redesign. Provider training will continue. (Fig. 4b, SPM 2, Act. 1)

PRAMS data will be collected and referenced to measure smoking rates before, during, and after pregnancy; quit rates; relapse rates; third trimester smoking trends; and disparities between groups. (Fig. 4b, SPM 2, Act. 6)

Inform MSS and prenatal providers about availability and use of the FAX back referral system for pregnant women (Fig. 4b, SPM 2, Act. 7)

Continue to disseminate the Smoking Cessation During Pregnancy best practice booklet. (Fig. 4b, SPM 2, Act. 3)

Tobacco Cessation training will continue for PHNs.

State Performance Measure 3: *Percent of women who receive counseling from their prenatal health care provider on tests for identifying birth defects or genetic disease.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	90	90.1	90.2	90.3	90.4
Annual Indicator	87.0	88.0	89.0	87.6	87.6
Numerator	68125	67673	67218	68066	
Denominator	78291	76881	75526	77701	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective					

Notes - 2002

THIS SPM WILL CHANGE FOR THE 2005-2009 NEEDS ASSESSMENT. IT WILL NOW BE A COMBINATION OF THE PREVIOUS SPMs 3, 6,& 8: "The percent of women who are screened during prenatal care for smoking, alcohol use, illegal drug use, HIV status, postpartum birth control plans, domestic violence, and receive counseling on tests for birth defects or genetic diseases." PLEASE SEE THE NEW SPM 3 FOR MORE DETAILS.

The percent of women who received counseling from their prenatal health care provider on tests for identifying birth defects of genetic disease.

The source for the data is the 2002 Washington State PRAMS. The measure is defined as the estimated proportion of women who reported that their health care provider talked to them about genetic testing or birth defect screening. The denominator was obtained from the live birth file, for Washington residents with plurality of 1 or first birth order. Note- we have revised the denominator and numerator data for the previous year based on the new methodology for the denominator.

Notes - 2003

The source for the data is the 2003 Washington State PRAMS. The 2003 data are delayed at the

CDC and were unavailable. The measure is defined as the estimated proportion of women who reported that their health care provider talked to them about genetic testing or birth defect screening. The denominator was obtained from the live birth file. Note- we have revised the denominator and numerator data for the previous year based on the new methodology for the denominator.

Notes - 2004

Data were unavailable for 2004.

a. Last Year's Accomplishments

Washington State Genetics Minimum Data Set reveals that over 6,600 families received prenatal diagnosis genetic counseling through the Regional Genetic clinic system in calendar year 2004. This was approximately a 4 percent increase over the previous year. (Fig. 4b, SPM 3, Act. 3)

In addition, PRAMS data are collected that ask women if they recall their prenatal care provider discussing "doing tests to screen for birth defects or diseases that run in your family." The most current PRAMS data available are for 2002 and show that 89 percent of women were counseled by their providers about birth defects or genetic disorders. This figure is not significantly different than in past years. These data assist the genetics program in identifying effectiveness of outreach and education aimed at providers to increase genetic screening. (Fig. 4b, SPM 3, Act. 4)

A day-long meeting was held for genetic counselors that included educational presentations about the genetics of hearing loss, as well as a peer review session, during which counselors presented interesting and challenging cases to their peers as a learning opportunity.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Send genetic brochure through HMHB with prenatal mailings.		X		
2. Send informational mailings to obstetric providers about prevention or testing for birth defects or genetic disease.			X	
3. Collect and analyze data from the Regional Genetic Clinics minimum dataset.				X
4. Collect and reference PRAMS data to measure percent of women offered genetic testing.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Support for Regional Genetics Clinics and compilation of their data using the Washington Minimum Genetic Data Set, as well as monitoring of PRAMS data related to genetic services. (Fig. 4b, SPM 3, Act. 3, 4)

Brochures about genetic screening continue to be included in the Healthy Mothers Healthy Babies educational packets distributed to women contacting the toll-free service. (Fig. 4b, SPM 3, Act. 1)

Another peer review meeting for genetic counselors is being planned for 2005. (Fig. 4b, SPM 3, Act.

5)

c. Plan for the Coming Year

OMCH has combined measures 3, 6, and 8 into a single performance measure and will continue the related activities through the year 2010.

The Genetic Services Section will continue to support services through the RGCs, compile data from the Washington Minimum Genetic Data Set and PRAMS to monitor prenatal diagnosis educational trends, and continue to support Healthy Mothers Healthy Babies for distributing educational brochures through their mailings. (Fig. 4b, SPM 3, Act. 1, 3, 4)

State Performance Measure 4: *Establish state and local capacity for determining the prevalence of children with special health care needs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	40	60	80	100	100
Annual Indicator	40	63	80	100	100
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective					

Notes - 2002

THIS SPM HAS BEEN DISCONTINUED FOR THE 2005-2009 NEEDS ASSESSMENT.

Data source: Washington CSHCN Program.
NOTE: UNABLE TO PROVIDE BENCHMARKS FOR YEARS 1 AND 2 HERE DUE TO SPACE LIMITATIONS
Year 3 (10/2001-9/2002) Target: 60% / Cumulative Score: 63%
7. Explore feasibility of integrating state data systems to assess prevalence of children with special needs.
*Collaborated with partnering State Agencies under the auspices of the WISE (Washington Integrated Services Enhancement) Grant. WISE Grant Integrated taskforce agreed that linking data systems would provide information on the prevalence of children with special health care needs in the state system. Collaborators include ITEIP, OSPI, DSHS.
8. Continue to explore data linkages and additional data sources for CSHCN.
*Count Me In report created to describe the usefulness of using the BRFSS methodology in assessing the prevalence in children with special health care needs.
v Contracted with the Center for Children with Special Needs to analyze National CSHCN Survey for Washington State, birth certificate data linked to hospitalization data to assess prevalence and health disparities, CAHPS (Consumer Assessment of Health Plans Survey) and to develop County Profiles for local CSHCN Programs.
9. Standardize the Child Health Intake Form (CHIF) automated data system

v Convened internal workgroup to develop quality improvement strategies and enhance Title V prevalence estimates.

Year 4 (10/2002-9/ 2003) Target: 80%
10.Improvement of Child Health Intake Form (CHIF) automated system
*Identified opportunities for improving the data quality of the Child Health Intake Form (CHIF) automated system. Three computer trainings with local CSHCN Coordinators and support staff aimed to standardize date entry and increase reporting capacity. Workgroup sessions with the local staff produced potential standard criteria that will be compiled and shared in June 2003 for review.
11. Develop a work plan to target data systems beyond the public sector to learn about the prevalence of children with special needs. Included in this plan will be outreach to private insurers, Indian Health, military, Basic Health, undocumented and the uninsured. Developing relationships with these other systems and identifying barriers to securing.
12.Initiate BD surveillance pilot.
*Pilot initiated and will coordinate with local CSHCN Coordinators to implement objectives.
Year 5 (10/2003-9/2004) Target: 100%
13.Implement new CHIF Criteria Standard and provide guidance and ongoing training to maintain standardization of data for local CSHCN Programs.
14.Contract with the Center for Children with Special Needs to sustain analytic work on the anticipated release of MCHB Child Health Survey results and other sources of data for children with special needs in Washington State.
15.Update Assessment Plan and explore developing MCHA capacity to analyze National CSHCN Survey data.

Notes - 2003

The source of the data is the Washington State CSHCN Program.
Year 5 (October 2003-September 2004) Target: 100%
Score: Cumulative Score: 100%

NOTE: UNABLE TO PROVIDE BENCHMARKS FOR YEARS 1-4 HERE DUE TO SPACE LIMITATIONS

Year 1 (10/1999-9/2000) Score 26%
Year 2 (10/2000-9/2001) Score 40%
Year 3 (10/2001-9/2002) Score 60%
Year 4 (10/2002-9/2003) Score 80%

*Implement new CHIF Criteria Standard and provide guidance and ongoing training to maintain standardization of data for local CSHCN Programs.
In collaboration with the local CSHCN Programs, a new CHIF criteria was developed and implemented. Guidance from the CSHCN Program and ongoing technical assistance has been provided to maintain the quality improvement strategy. An initial evaluation of the data will occur in spring 2005 to review completeness of data fields and any unusual reporting.
* Contract with the Center for Children with Special Needs to sustain analytical work on the anticipated release of MCHB Child Health Survey results and other sources of data for children with special needs in Washington State.
A Washington State Report on Children and Youth with Special Health Care needs is being developed and will be released July 2005. Included in the report will be county profiles and results from the 2002 Healthy Youth Survey, 2003 BRFSS, 2001 NS-CSHCN. The MCHB Child Health Survey and 2004 Healthy Youth Survey will be analyzed by MCH Assessment. Pertinent disability questions from these surveys will analyzed by MCH Assessment.
*Update Assessment Plan and explore developing MCHA capacity to analyze National CSHCN Survey data.
CSHCN Assessment Plan is currently under revision and is in draft form. Preliminary discussions

have been taken to increase capacity of DOH to analyze the 2005 NS-CSHCN Survey.

Notes - 2004

This is the final year for this State Performance Measure.

a. Last Year's Accomplishments

Work was finalized on hospital discharge data regarding disparities among children admitted for chronic conditions. Information about chronic illness was utilized in county profile reports developed under the contract with CHRMC. (Fig. 4b, SPM 4, Act. 1)

"Painting the Picture," a publication containing Washington State data sources on children with special needs, was drafted and the plan for dissemination to state stakeholders and other states is being finalized. The plan for next steps will be integrated in the 2005 work plan of the CHRMC contract. (Fig. 4b, SPM 4, Act. 2)

Although new procedures for the Child Health Intake Form were not required to be instituted until January 2004, year-end data from local health jurisdictions for children served in 2003 was greatly improved with more complete data reported on each child. Feedback was provided to those who submitted the data, congratulating them on their efforts. (Fig. 4b, SPM 4, Act. 3)

The CSHCN Program provided recommendations to two managed care organizations, the Community Health Plan of Washington (CHPW) and Group Health. These health plans were eager to identify children with special needs in their systems so as to determine prevalence, and develop appropriate educational materials and care plans for providers to improve services.

CHILD Profile and partners reviewed the Ages and Stages Questionnaire (ASQ) pilot results to determine the feasibility of utilizing the CHILD Profile system for statewide dissemination. The pilot tested whether disseminating the ASQ via mail to parents of children 18 months of age in Snohomish County would result in better identification of children who have developmental delays. Initial results of this pilot identified 2.9 percent of Snohomish County children as having a possible delay. (Fig. 4b, SPM 4, Act. 4)

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Contract with the CCSN to analyze annual hospital discharge data in order to assess prevalence and disparities.				X
2. Contract with CCSN to provide ongoing analysis of available data on children with special needs, including the NCSHCN Survey and CAHPS.				X
3. Standardize the criteria for the CHIF electronic system between all LHJs and neurodevelopmental contractors.				X
4. Develop alternative strategies to promote identification of children and youth with special needs in existing data systems and/or surveys of governmental and private entities.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CSHCN was provided with data analysis of the hospital discharge data and will discontinue this contracted activity.

Efforts during this time period have been directed to using the WISE Grant's systems assessment in order to develop strategies for cross-systems integration of data. In October 2004, DOH contracted with Organizational Research Services (ORS) to evaluate the WISE grant. The evaluation focused on synthesizing lessons learned from pilot site projects and findings from the state-level System Assessment Report to contribute to recommendations for statewide change in local care systems. The report addressed pilot site experiences, successes, challenges, and outcomes while implementing integration goal areas; overall outcomes achieved by the WISE grant project; general observations of facilitators, and barriers to successful service integration of local care systems. Recommendations or next steps to successfully integrate services were gathered as well. This information, along with final committee reports, is being folded into final recommendations directed at state agencies and will be presented to stakeholders in summer 2005. (Fig. 4b, SPM4, Act. 1)

CSHCN contracted with CHRMC to create a data publication that would provide a comprehensive picture of children with special health care needs in Washington State, both locally and statewide, using National CSHCN Survey data, county profiles, and results of other MCH/CSHCN assessment activities. This publication will be completed in June 2005.

Individual county profiles are being disseminated to all local health jurisdictions to assist in describing the population of children with special needs in their community. Technical assistance on ways to introduce a profile in the community or program is provided. (Fig. 4b, SPM 4, Act. 2)

Improvement in the Child Health Intake Form data has continued through ongoing individual training of local health staff by the CSHCN Program's contractor, Strategic Services. Ongoing support is being provided to those counties identified with quality improvement needs. (Fig. 4b, SPM 4, Act. 3)

The Snohomish Medical Home Leadership Network Team and partners are using the results from the pilot dissemination of the Ages and Stages Questionnaire to determine the best and most cost-effective method to disseminate the questionnaire to parents statewide. (Fig. 4a, SPM 4, Act. 4)

c. Plan for the Coming Year

This performance measure has been achieved and OMCH does not anticipate including this performance measure in Washington State MCH Block Grant applications and reports over the next 5 years. Sources for ongoing data about children with special health care needs have been identified and incorporated into other work. However, activities to enhance quality of CSHCN Program data (CHIF) will continue through our contractor Strategic Services; collaborations with managed care and other agencies will also be sought; and recommendations from the WISE grant regarding data will be incorporated into the way the CSHCN Program goes forward with improving systems of care for children with special needs.

State Performance Measure 5: *To reduce the prevalence of 8th grade youth who report smoking one or more cigarettes in the last 30 days.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance					

Objective		12.3	12.0	11.8	11.5
Annual Indicator	12.5	12.5	9.2	9.2	7.8
Numerator	9644	9644	6774	6774	6414
Denominator	77149	77149	73634	73634	82234
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective					

Notes - 2002

THIS SPM HAS BEEN DISCONTINUED FOR THE 2005-2009 NEEDS ASSESSMENT.

To reduce the prevalence of the grade youth who report smoking one or more cigarettes in the last 30 days.
The percentage of children in the 8th grade that had smoked cigarettes within the past 30 days is 9.2% (95% CI is ±1.1). These data were obtained from the Washington State 2002 Healthy Youth Survey. The Healthy Youth Survey is a collaborative effort of the Office of the Superintendent of Public Instruction, the Department of Health, the Department of Social and Health Service's Division of Alcohol and Substance Abuse, and the Office of Community Development. In the Fall of 2002, students in grades 6, 8, 10 and 12 answered questions about safety and violence, physical activity and diet, alcohol, tobacco and other drug use, and related risk and protective factors. A simple random sample of schools was drawn. All students in grades 6, 8, 10, 12 in selected schools were invited to participate. The Healthy Youth Survey will next be administered in the Fall of 2004. The Healthy Youth Survey provides important information about adolescents in Washington. County prevention coordinators, community mobilization coalitions, community public health and safety networks, and others use this information to guide policy and programs that serve youth. The information from the Healthy Youth Survey can be used to identify trends in the patterns of behavior over time. The state-level data can be used to compare Washington to other states that do similar surveys and to the nation. The denominator represents the number of children enrolled in the 8th grade public schools in 2002, as reported in the 2002 Juvenile Justine Report, Office of Juvenile Justice.

Notes - 2003

No new data

The percentage of children in the 8th grade that had smoked cigarettes within the past 30 days is 9.2% (95% CI is ±1.1). These data were obtained from the Washington State 2002 Healthy Youth Survey. The Healthy Youth Survey is a collaborative effort of the Office of the Superintendent of Public Instruction, the Department of Health, the Department of Social and Health Service's Division of Alcohol and Substance Abuse, and the Office of Community Development. In the Fall of 2002, students in grades 6, 8, 10 and 12 answered questions about safety and violence, physical activity and diet, alcohol, tobacco and other drug use, and related risk and protective factors. A simple random sample of schools was drawn. All students in grades 6, 8, 10, 12 in selected schools were invited to participate. The Healthy Youth Survey will next be administered in the Fall of 2004. The Healthy Youth Survey provides important information about adolescents in Washington. County prevention coordinators, community mobilization coalitions, community public health and safety networks, and others use this information to guide policy and programs that serve youth. The information from the Healthy Youth Survey can be used to identify trends in the patterns of behavior over time. The state-level data can be used to compare Washington to other states that do similar surveys and to the nation. The denominator represents the number of children enrolled in the 8th grade public schools in 2002, as reported in the 2002 Juvenile Justine Report, Office of Juvenile Justice.

Notes - 2004

The percentage of children in the 8th grade that had smoked cigarettes within the past 30 days is 7.8%. These data were obtained from the Washington State 2004 Healthy Youth Survey. The Healthy Youth Survey is a collaborative effort of the Office of the Superintendent of Public Instruction, the Department of Health, the Department of Social and Health Service's Division of Alcohol and Substance Abuse, and the Office of Community Development. In the Fall of 2004, students in grades 6, 8, 10 and 12 answered questions about safety and violence, physical activity and diet, alcohol, tobacco and other drug use, and related risk and protective factors. A simple random sample of schools was drawn. All students in grades 6, 8, 10, 12 in selected schools were invited to participate. The Healthy Youth Survey provides important information about adolescents in Washington. County prevention coordinators, community mobilization coalitions, community public health and safety networks, and others use this information to guide policy and programs that serve youth. The information from the Healthy Youth Survey can be used to identify trends in the patterns of behavior over time. The state-level data can be used to compare Washington to other states that do similar surveys and to the nation. The denominator represents the number of children enrolled in the 8th grade public schools in 2003, as reported in the 2004 Juvenile Justine Report, Office of Juvenile Justice.

a. Last Year's Accomplishments

The OMCH participated on the Joint Survey Planning Committee (JSPC) to plan, recruit, and train for the 2004 Healthy Youth Survey. Other members of the JSPC include the DOH's Tobacco Prevention and Control Program, the Office of Non-Infectious Epidemiology, the OPSI, DASA, and the Department of Community, Trade and Economic Development. The Healthy Youth Survey was developed in order to reduce the burden to schools and assure all state and local agencies get data on a variety of health-related topics, including use of tobacco products by youth. This effort is crucial for the needs assessment process for the adolescent population. (Fig. 4b, SPM 5, Act. 1)

The OMCH also coordinated the development of a statewide Adolescent Health Plan with the TPCP. (Fig. 4b, SPM 5, Act. 2)

Local efforts to reduce the rate of youth using tobacco products included: providing elementary school and tribal health fair presentations directed at youth tobacco use; and teaming staff from oral health and tobacco programs to provide information to children, preschool through 6th grade.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participate with DOH Tobacco program in the administration of the Healthy Youth Survey.				X
2. Develop a statewide Adolescent Health Plan that includes tobacco use.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The OMCH continues to collaborate with the DOH Tobacco Prevention and Control Program on the Healthy Youth Survey, the development of a statewide Adolescent Health Plan, and planning a conference on media literacy. (Fig. 4b, SPM 5, Act. 1 , 2)

c. Plan for the Coming Year

At this stage of the 5 year needs assessment, OMCH does not anticipate including this performance measure in Washington State MCH Block Grant applications and reports over the next 5 years. However, because tobacco use is included in one of the 9 priorities, a performance measure may be added.

The OMCH will continue to collaborate with the DOH Tobacco Prevention and Control Program on the Healthy Youth Survey, the development of a statewide Adolescent Health Plan, and planning a conference on media literacy. (Fig. 4b, SPM 5, Act. 1, 2)

State Performance Measure 6: *The percent of women who are screened for domestic violence during their prenatal care visits. (SP 11 Revised.)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	40%	42%	44%	46%	48%
Annual Indicator	40.0	49.0	46.0	48.9	48.9
Numerator	31506	37849	34205	37996	
Denominator	78765	77242	74358	77701	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective					

Notes - 2002

THIS SPM HAS BEEN COMBINED WITH SPM 3 & 8, TO CREATE THE NEW SPM 3 FOR THE 2005-2009 NEEDS ASSESSMENT. PLEASE SEE THE NEW SPM 3 FOR MORE DETAILS.

The percent of Pregnant women screened for domestic violence during their prenatal care visits. The source of the data is 2002 Washington State Pregnancy Risk Assessment Monitoring System (PRAMS) survey. The measure is defined as the estimated proportion of women who reported that their health care provider talked to them about physical abuse by their husbands or partners. The denominator was obtained from the live birth file, for Washington residents. Note- we have revised the denominator and numerator data for the previous year based on the new methodology for the denominator.

Notes - 2003

The source of the data is 2003 Washington State Pregnancy Risk Assessment Monitoring System (PRAMS) survey. The measure is defined as the estimated proportion of women who reported that their health care provider talked to them about physical abuse by their husbands or partners.

Notes - 2004

Data were unavailable for 2004.

a. Last Year's Accomplishments

The MCHB/SPRANS grant no-cost extension continued until April 2004. The "Perinatal Domestic Violence Identification Services" (PDVIS) g was revised to include changes from review and pilot sites. A dissemination plan was developed and the guide was distributed within Washington State and posted on the web. Presentations on the guide were given from April to December 2004. (Fig. 4, SPM 6, Act. 1)

MIH promoted the provider materials from the PDVIS guide and implemented strategies directed at increasing screening and intervention and referral by providers, including the Project Partnership. The Project Partnership is a pilot project to establish four Regional DV Liaisons to promote provider screening and referral outlined in the DV booklet. (Fig.4, SPM 6, Act. 1, 2)

MIH continued distribution of the "Domestic Violence in Pregnancy: Guidelines for Screening and Referral" (DVPG) booklet to perinatal providers serving pregnant and postpartum women. (Fig.4, SPM6, Act.2)

MIH distributed the "Perinatal Partnerships Against Domestic Violence" (PPADV) curriculum to new trainers through the Washington State Coalition Against Domestic Violence (WSCADV). (Fig.4, SPM 6, Act. 3)

MIH consulted with the successful applicant for the revision of the PPADV curriculum to address all victims of violence in a medical setting. (Fig. 4, SPM 6, Act. 3)

MIH reviewed PRAMS data for changes in DV prevalence (physical and emotional) and provider screening practices. (Fig. 4, SPM6, Act. 4)

The "Domestic Violence and Pregnancy" fact sheet to reflect 2001-02 PRAMS data. (Fig. 4, SPM 6, Act. 4)

Promoted MCH DV projects at professional conferences. (Fig. 4, SPM 6, Act. 5)

MIH provided technical assistance support to hospitals, doctors, and clinics for establishing and improving protocols, tool development, and intervention strategies for pregnant and postpartum women. (Fig.4, SPM 6, Act.6)

Local health efforts to increase the percent of women who are screened for domestic violence during their prenatal care visits included extending domestic violence services to the community health services center for Hispanic families; providing parenting classes; providing education about drugs, alcohol, and domestic violence; and tracking information in data systems. (Fig. 4, SPM 6, Act. 6)

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Perinatal DV Identification Services (PDVIS) guide is developed, tested, and revised then redistributed throughout the state.				X
2. Promote universal screening and referral of domestic violence through the distribution of the DVPG booklet and pilot four regional DV Liaisons to promote the content of the booklet.				X

3. Revise the PPADV curriculum to include all types of violence and distribute to trainers across the state.				**X**
4. Update “Domestic Violence and Pregnancy” fact sheet using PRAMS data for changes in DV prevalence and provider screening practices annually and distribute across the state.				**X**
5. Promote MCH DV projects at professional conferences and meetings.				**X**
6. Provide technical assistance, information, and materials to local health care providers and community partners to increase the percentage of women screened for domestic violence during pregnancy.				**X**
7. Participate in efforts to promote the development of healthy relationships in youth.				**X**
8. Participate in the internal MCH Family Violence Prevention Workgroup and develop partnerships with complimentary external workgroups such as the CPASDV and the WSCADV.				**X**
9. Assist in the distribution of other materials related to domestic violence including the safety cards produced by the state Department of Social and Health Services.			**X**	
10.				

b. Current Activities

MIH is continuing to promote the PDVIS guide materials. As of December 1, 2004, the technical assistance guide was distributed to 112 individuals in many types of organizations including local health departments, community clinics, WIC clinics, community action agencies, universities, and hospitals. The total number of guides distributed is 101 hard copies, 60 CD-ROMS, and 5 Adobe/Acrobat files. (Fig. 4b, SPM 6, Act. 1)

MIH is promoting universal screening through distribution of the DVPG booklet.
(Fig. 4, SPM 6, Act. 2)

MIH is continuing to promote the PPADV curriculum. (Fig. 4, SPM6, Act. 3)

The PPDAV curriculum is being revised to include sexual assault issues. (Fig.4, SPM 6, Act. 3)

PRAMS data for 2003-04 will be reviewed for changes in prevalence and provider practices. (Fig. 4b, SPM 6, Act. 4)

MIH staff will participate on an expert panel to direct the completion of standardized screening and a pilot project funded by a DHHS grant awarded to a local health jurisdiction. (Fig. 4, SPM 6, Act. 6)

MIH is continuing the Healthy Relationships Project and partnership with WSCADV and Community Partners Against Sexual and Domestic Violence (CPASDV) to write grants. (Fig. 4b, SPM 6, Act. 7, 8)

MIH is continuing the Project Partnership. (Fig. 4, SPM 6, Act. 8)

The PPADV has reorganized to be the external workgroup to the DOH Family Violence Prevention Workgroup on domestic violence and sexual assault issues. (Fig. 4, SPM 6, Act. 8)

MIH continues to distribute booklets at professional meetings targeting physicians and OB care providers and MAA personnel. (Fig. 4, SPM 6, Act. 9)

c. Plan for the Coming Year

OMCH has combined measures 3, 6, and 8 into a single performance measure and will continue the related activities through the year 2010.

MIH will continue to promote the PDVIS Guide materials for providers. (Fig.4, SPM 6, Act. 1)

MIH will continue to promote universal screening through distribution of the DVPG booklet. (Fig. 4b, SPM 6, Act. 2)

MIH will promote and distribute the revised PPADV curriculum. (Fig. 4, SPM6, Act. 3)

MIH will revise and distribute the "Domestic Violence and Pregnancy" fact sheet to reflect 2003-04 PRAMS data. (Fig. 4, SPM 6, Act. 4)

MIH will continue to provide technical assistance, information, and materials to health care providers and their community partners to increase skills in screening and intervening in domestic violence. (Fig. 4, SPM 6, Act. 6)

MIH will work on the Healthy Relationships Project. (Fig. 4, SPM 6, Act. 7)

MIH will continue activities with internal and external workgroups to promote universal screening for violence. (Fig. 4, SPM 6, Act. 8)

MIH will distribute booklets and safety cards at professional meetings targeting physicians and OB care providers and MAA personnel. (Fig. 4, SPM 6, Act. 9)

State Performance Measure 7: *Increase the capacity of MCH to assess mental health needs of the child and adolescent population and to promote early identification, prevention and intervention services.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective		20	49	67	80
Annual Indicator	20.0	20.0	40.0	56	76
Numerator	3	3	6		
Denominator	15	15	15		
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective					

Notes - 2002

THIS SPM HAS BEEN DISCONTINUED FOR THE 2005-2009 NEEDS ASSESSMENT. PLEASE SEE THE NEW SPM 4, FOR THE VARIATION AND MORE DETAILS.

Benchmarks:
NOTE: YEAR 1 BENCHMARKS NOT SHOWN DUE TO SPACE LIMITATIONS

Year 2 (10/2001- 9/2002) Target 47% / Cumulative Score 43.3%
4. Surveyed other state MCH offices for strategies they use to promote early identification and intervention.
· Conducted search of all other state's MCH plans and reports to identify states with similar strategies. Followed up with specific states that most closely aligned with Washington. (Score 6.6%)
5. Consulted with local and state constituents (including consumers) to identify strategies MCH will promote for enhancing early identification, prevention and intervention in Washington. (Score 3.3%)
· Followed up with LHJs with report compiled in Year 1 and formed relationship with state counterparts in Children's Mental Health. Participate in DSHS Children's Mental Health Advocacy Committee, which also has consumer representation.
· Participated in planning with the University of Washington for a multi-state Children's Mental Health Symposium held in the Fall of 2002.Work from this symposium will provide information to help develop intervention strategies.
· Have not completed identification of strategies due to need for additional assessment data (need was identified in Year 1). Will continue to work on this in Year 3.
6. Continued to monitor level of need for mental health services and degree of access achieved using existing databases. (Score 6.6%)
· Participate on DSHS Children's Mental Health Committee which helps monitor issues related to need and access for this population.
· Reviewed Joint Health Legislative and Audit Review Committee (JLARC) report released August 2002: "Children's Mental Health.
7. Identified need for additional data collection regarding mental health services and opportunities for additional data collection. (Score 6.6%)
· The work from Year 1 and Year2 has highlighted the need for additional assessment data. MCH is seeking additional resources to assist with this data collection, including submitting an application for a CDC Public Health Prevention Service fellow. We will continue to work on additional data collection in Year 3.

Year 3 (10/2002- 9/2003) Target 67% (10 of 15 benchmarks)
8. Solicited additional funding for mental health assessment, as needed.
9. Developed a Mental Health promotion plan for MCH
10. Solicited funding to implement the plan.

Year 4 (10/2003- 9/2004) Target 80%
11. Began implementation of plan, as resources allow.
12. Collected and analyze information from plan implementation.

Year 5 (10/ 2004- 9/2005) Target 100%
13. Continued implementation of MCH Mental Health promotion plan strategies.
14. Continued data collection and evaluate implementation strategies.
15. Presented process development and strategy at state/national conferences

Notes - 2003

Target 67% (10 of 15 benchmarks)
Year 3 Score: 12.2%
Cumulative Score: 55.5 %
1. Solicited additional funding for mental health assessment, as needed. (Score: 6.6%)
· MCH solicited additional resources to assist with mental health assessment. An application was submitted for a CDC Public Health Prevention Service fellow. The application was not accepted. MCH funding has been allocated for a Child Development Specialist who started March 2003 to focus on mental health needs in the MCH population.
· Developed a Mental Health promotion plan for MCH(Score:6.6%)
· The Child Development Specialist developed a work plan to address this objective. Included in the work plan are the following strategies:
- Disseminate information about children's mental health Partnerships for Supporting Children's

Mental Health email distribution list. Seventy people were on the list by September 2003.
- Participate in regional meetings with local MCH staff to identify issues, barriers and effective strategies related to mental health and to facilitate coordination of state and local efforts.
- Conduct a literature review to identify children's mental health policy issues, and planning and implementation strategies.
· A work plan was also developed for the OMCH Mental Health Work Group. This Work Group coordinates the mental health promotion, prevention and intervention efforts within OMCH at the state level. It also connects with broader public health initiatives, for example physical activity and nutrition. The Work Group also provides technical assistance and serves in an advisory capacity to the Child Development Specialist
· OMCH worked with the Washington Health Foundation to bring together state and local, public and private partners to begin to address identification of issues, coordination of services and planning for the future of children's mental health in Washington State. This group is called Partnerships for Supporting Children's Mental Health. They are looking at children's mental health across the continuum of health promotion, prevention, intervention and treatment. Partnerships include the Division of Mental Health, in the Department of Social and Health Services, Region X Health Resources and Services Administration, and the State Education Agency. The information gathered by this group will inform the MCH planning process. A desired outcome of this initiative is a mental health promotion plan for MCH.
· Efforts have been made to coordinate MCH mental health planning with other MCH planning efforts including the Early Childhood Comprehensive Systems Grant, the Adolescent Health Improvement Plan and the WISE Grant for CSHCN.
2. Solicited funding to implement the plan. (Score:0%)
The OMCH Mental Health Work Group has had discussions regarding reapplying for the CDC Public Health Prevention Service fellow, possible interns to work on assessment and presenting a proposal to the OMCH Management Team at a future date.

Notes - 2004

Year 4 (October 2003-September 2004) Target 80% (12 of 15 benchmarks) Score: 76%

*Began implementation of plan, as resources allow.
•MCH began implementation of the mental health promotion plan, within available resources. •MCH continued to allocate a .75 FTE for a Child Development Specialist (CDS) in the Child and Adolescent Health section who coordinated the implementation of the mental health promotion plan.•Promotion of mental health in OMCH activities, with external partners and planning efforts, including Early Childhood Comprehensive Systems Grant and the Statewide Adolescent Health Plan. •Internal OMCH Mental Health workgroup continued to meet to coordinate, identify, and plan activities across OMCH and implement the plan. •DOH continued to convene the stakeholder group Partnerships for Supporting Children's Mental Health (Partnerships); identified current activities, barriers, and socio-emotional needs•CDS continued to disseminate information via the Partnerships for Supporting Children's Mental Health email distribution list. As of September 2004, 100 people were on the list. •CDS represented DOH on the DSHS Children's Mental Health Workgroup; developing recommendations for more effective/coordinated children's mental health services across DSHS divisions.•CHILD Profile (CP) began incorporating issues and preventive measures identified by the OMCH Mental Health work group in mailings. Partnerships included Talaris Research Institute and Project Lift-Off to disseminate their educational materials •Continued efforts for coordination and implementation
*Collected and analyze information from plan implementation.
•Completion of a Washington children's mental health needs assessment. This project occurred from September 2004 to June 2005 as a collaborative effort between the CDC's Public Health Prevention Service and OMCH. Washington State data, prior research, and literature were analyzed to distinguish trends in mental health and mental illness among specific populations of children. Key informant interviews were held, and findings will be used to inform an OMCH priority around social, emotional and mental health as well as provide a backdrop for updating the OMCH mental health promotion plan. •Information gathered from the OMCH Mental Health Workgroup and Partnerships

for Supporting Children's Mental Health (see above) was also used to guide and inform the implementation of the plan.

a. Last Year's Accomplishments

The Child Development Specialist (CDS) in the Child and Adolescent Health Section continued to look for opportunities to promote mental health in OMCH activities with external partners and in related planning efforts, including Early Childhood Comprehensive Systems Grant and the Statewide Adolescent Health Plan. (Fig. 4b, SPM 7, Act. 1, 2, 3)

The internal OMCH Mental Health workgroup continued to meet to coordinate, identify, and plan activities across OMCH and implement its workplan. DOH continued to convene the stakeholder group Partnerships for Supporting Children's Mental Health (Partnerships). Partnerships worked to identify current activities, barriers, and needs related to children's social, emotional, and mental health. (Fig. 4b, SPM 7, Act. 1, 2)

The CDS represented DOH on the DSHS Children's Mental Health workgroup that included representatives from mental health, child welfare, education, juvenile rehabilitation, tribal representatives, providers, and family members. They developed recommendations for more effective and coordinated children's mental health services across DSHS divisions. (Fig. 4b, SPM 7, Act. 3)

MCH was successful in securing additional resources via a Public Health Prevention Specialist (PHPS), from CDC to assist with mental health assessment, planning, and implementation. The PHPS started work in September 2004.

A two-day training on Bright Futures Mental Health was provided for school nurses from across the state. The nurses developed action plans and a follow-up meeting is scheduled for May 2005.

CSHCN, through a contract with Children's Regional Hospital and Medical Center, developed an on-line Mental Health Toolkit that provides information for professionals and parents on mental health topics.

CHILD Profile (CP) began incorporating issues and preventive measures identified by the OMCH Mental Health work group in CP Health Promotion mailings on social and emotional development. The Talaris Research Institute partnered with CP to revise and distribute four of their "Spotlight" educational materials. These materials include information on how caregivers can promote social and emotional development in children. CP also partnered with Project Lift-Off to disseminate their "Getting School Ready" booklet to parents of four year olds. This booklet included a section on getting your child socially and emotionally ready for school. (Fig. 4b, SPM 7, Act. 4)

Local health efforts for this performance measure included participating on community mental health advisory groups to ensure the mental health needs of children are represented; inclusion of mental health needs for teen moms in a federal grant application based on the results of a maternal depression survey; linkages to mental health services for children; and demonstration that students with access to clinical services and increased connection to adults reported improved mental health, less violence, and less stress.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Integrate mental health capacity into existing OMCH programs through the OMCH Mental Health Workgroup.				X

2. Collect information and data related to the need for mental health services in the MCH population.				X
3. Collaborate with DSHS Division of Mental Health and others to increase partnering on mental health activities including prevention and early intervention.				X
4. Disseminate Social and Emotional Development messages to parents of children 0 - 6 years of age through the CHILD Profile Health Promotion System.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Child Development Specialist position continues to look for opportunities to promote children's mental health in OMCH activities and with external partners, and to coordinate with related internal and external planning efforts. Planning efforts include the Early Childhood Comprehensive Systems Grant and the Statewide Adolescent Health Plan. (Fig. 4b, SPM 7, Act. 1, 2, 3)

The internal OMCH Mental Health workgroup continues to implement its workplan, including regular meetings to coordinate MCH mental health activities. (Fig. 4b, SPM 7, Act. 1, 2)

Partnerships for Supporting Children's Mental Health, the interagency workgroup, will continue to meet to identify issues and opportunities for coordination of services and planning for the future of children's mental health in Washington State. Ideas and information will continue to be shared between this group and the OMCH Mental Health workgroup. (Fig. 4b, SPM 7, Act. 1, 2, 3)

Beginning September 2004, the PHPS has worked on completing a statewide children's mental health needs assessment. His activities included completing a comprehensive literature review of children's mental health, developing a children's mental health needs assessment framework, data source identification and analysis, conducting 47 children's mental health key informant interviews, aggregating data into a consensus document, making recommendations for the provision of public health/mental health services, and disseminating the consensus document. Other activities include submitting abstracts for two conferences (APHA and WSJCH) and several preliminary data presentations.

The school nurses who participated in the Bright Futures Mental Health training (August 2004) are scheduled to meet in May 2005 to review the implementation of their action plans.

CHILD Profile is continuing to identify, through professional and parent groups, the issues and preventive measures related to social and emotional development that need to be incorporated in CP Health Promotion mailings. The Talaris Research Institute is expanding their partnership with CP to revise and distribute two additional "Spotlight" educational materials. These materials include information on how caregivers can promote social and emotional development in children. The current "Spotlights" are sent to parents in the 3 month, 12 month, 2 year, and 3 1/2 year mailings. CHILD Profile is continuing the partnership with Project Lift-Off to disseminate their "Getting School Ready" booklet to parents of 4 year old children in Washington State. (Fig. 4b, SPM 7, Act. 4)

c. Plan for the Coming Year

OMCH has revised and expanded this performance measure for Washington State's MCH Block Grant applications and reports for the next 5 years.

The CDS will continue to look for opportunities to promote mental health in OMCH activities and with external partners. She will continue to coordinate OMCH mental health activities with related planning efforts, including the Early Childhood Comprehensive Systems (ECCS) grant and the Statewide Adolescent Health Plan. The CDS will continue to serve as the lead for Social Emotional and Mental Health, one of five focus areas in the ECCS planning effort (now called Kids Matter: Improving Outcomes for Children in Washington State). (Fig. 4b, SPM 7, Act. 1, 2, 3)

The internal OMCH Mental Health workgroup will continue to meet to coordinate, identify, and plan activities across OMCH. The CDS and OMCH Mental Health workgroup will continue to implement their workplan. (Fig. 4b, SPM 7, Act. 1, 2) The OMCH mental health workplan will be updated and enhanced based on findings from the Children's Mental Health Needs Assessment and the MCH Needs Assessment and priority setting process.

The Public Health Prevention Specialist will continue to work with OMCH through September 2006. He will update the Children's Mental Health Needs Assessment. He is also planning to develop and implement a social marketing campaign focusing on reducing mental illness stigma.

DOH will continue to convene the stakeholder group Partnerships for Supporting Children's Mental Health. This group works to identify current activities, barriers, and needs related to children's mental health and children's social and emotional wellbeing in Washington State.

The CDS and PHPS will look for opportunities to share the OMCH mental health work at state and national conferences.

CHILD Profile will continue to seek input from professional and parent groups about which social and emotional development issues and preventive measures should be incorporated in the CP Health Promotion mailings. CHILD Profile and the Talaris Research Institute will continue to expand their partnership to distribute the "Spotlight" educational materials to parents of children 0 -- 6 years in Washington State. CHILD Profile and Project Lift-Off plan to continue their partnership to distribute the "Getting School Ready" booklet to parents of 4 year old children. (Fig. 4b, SPM 7, Act. 4)

State Performance Measure 8: *The percent of women who are screened during prenatal care visits for smoking, alcohol use, illegal drug use, HIV status, and postpartum birth control plans.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	57%	59%	61%	63%	65%
Annual Indicator	48.0	49.0	50.0	45.9	46
Numerator	37582	37672	38188	35665	
Denominator	78291	76881	76376	77701	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance					

Objective					

Notes - 2002

THIS SPM HAS BEEN COMBINED WITH SPM 3 & 6, TO CREATE THE NEW SPM 3 FOR THE 2005-2009 NEEDS ASSESSMENT. PLEASE SEE THE NEW SPM 3 FOR MORE DETAILS.

The percent of women who are screened during prenatal care visits for smoking, alcohol use, illegal drug use, HIV status, and postpartum birth control plans.
The source of these data is 2002 Washington State Pregnancy Risk Assessment Monitoring System (PRAMS) survey. The measure is defined as the estimated proportion of women who reported that their health care provider talked to them about smoking, alcohol use, illegal drug use, getting tested for HIV status and postpartum birth control plans. The denominator was obtained from the live birth file, for Washington residents. Note- we have revised the denominator and numerator data for the previous year based on the new methodology for the denominator.

Notes - 2003

The source of these data is 2003 Washington State Pregnancy Risk Assessment Monitoring System (PRAMS) survey. The measure is defined as the estimated proportion of women who reported that their health care provider talked to them about smoking, alcohol use, illegal drug use, getting tested for HIV status and postpartum birth control plans.

Notes - 2004

Data were unavailable for 2004.

a. Last Year's Accomplishments

MIH completed focus groups with obstetric providers in Washington to determine effective strategies for influencing and improving screening and intervention for prenatal substance abuse (including tobacco) and violence. Four focus groups, two in-person and two by phone, were conducted in October and November 2003. A total of 36 providers participated in this research which was completed in December 2003. Physicians were most interested in practical, concise information for themselves and their office staff. MIH is now developing a work plan of effective strategies for 2004-2005. (Fig. 4b, SPM 8, Act. 1, 3, 4)

The Maternal and Infant Health section, in collaboration with HIV/AIDS program, Northwest Family Center, University of Washington School of Medicine, Children's Hospital and Regional Medical Center, and the Northwest Regional Perinatal Program, developed "Guidelines for Management of HIV+ Pregnant Women Birthing in Washington Hospitals." These checklists for hospitals and prenatal providers outline appropriate in-hospital care including lab tests and medications for laboring mothers and their newborns. This effort was in response to several episodes when community hospitals did not have the appropriate medications available when an HIV positive pregnant woman presented in labor. These yellow laminated checklists are available for posting and as Word documents that can be individualized and placed in the medical record. Dissemination is through the Regional Perinatal Programs, DOH website, and at medical conferences. (Fig. 4b, SPM 8, Act. 2)

MIH continued to distribute the "Screening and Management of Maternal HIV Infection" best practice booklet. MIH continued to inform providers about the Washington Administrative Code changes and their responsibilities. (Fig. 4b, SPM 8, Act. 2)

MIH continued to work with MAA and provider groups to increase the use of the Medicaid Smoking Cessation benefit. (Fig. 4b, SPM 2, Act. 3, 4)

MIH continued to work with provider groups to improve the skill and effectiveness of smoking cessation intervention by obstetric providers. (Fig. 4b, SPM 2, Act. 5)

First Steps programs which exist at most LHJs incorporate these screenings and interventions for these behaviors. Clients who are not eligible for First Steps are often covered by MCH and/or local

funding sources to accomplish this same standard of care. One LHJ reported that MCH funding allowed them to serve families who were not eligible for services through another dedicated funding source, including those whose First Steps eligibility ended.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop and distribute alcohol/drug screening best practice materials.				X
2. Inform and promote routine HIV testing during pregnancy by medical providers. Disseminate checklists for HIV management during intrapartum to hospitals and providers.				X
3. Work with MAA to implement the Smoking Cessation benefit for pregnant women.				X
4. Disseminate the tobacco intervention best practice guide to providers.			X	
5. Collect and reference PRAMS data to measure rates of screening and discussion during prenatal care for smoking, alcohol use, illegal drug use, HIV status, and postpartum birth control plans.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

MIH continues to provide best practice materials to providers to improve the skill and effectiveness of substance abuse screening. (Fig. 4b, SPM 8, Act. 1,4, 5)

MIH continues to inform medical care providers about HIV testing during pregnancy, including use of the rapid test in labor and delivery, and disseminate the best practice guide. (Fig. 4b, SPM 8, Act. 2)

MIH continues to work with MAA to reduce tobacco use by pregnant women by implementing the Smoking Cessation benefit, and disseminating the provider reference card. (Fig. 4b, SPM 8, Act. 4)

MIH is developing a workplan of effective strategies for 2004-05 to address physician need of practical, concise information for screening and intervention for prenatal substance abuse (including tobacco) and violence. (Fig. 4b, SPM 8, Act. 1)

MIH works with other MAA, OMCH, and other DOH programs to plan the prenatal medical chart review project. The review will enable MCH to assess the general quality of prenatal care as well as look at HIV testing, and screening for substance use and violence. (Fig. 4b, SPM 8, Act. 6)

c. Plan for the Coming Year

OMCH has combined measures 3, 6, and 8 into a single performance measure and will continue the related activities through the year 2010.

MIH will continue to provide best practices materials and training to providers to improve the skill and effectiveness of substance abuse screening. (Fig. 4b, SPM 8, Act. 1, 4)

MIH will continue to implement strategies identified in the strategic planning process aimed at providing professional education and improving provider screening skill and effectiveness. (Fig. 4b, SPM 8, Act. 1, 4, 5, 6)

Continue to inform medical care providers about HIV testing during pregnancy and disseminate the best practice guide. Complete revision of the Maternal HIV booklet and disseminate (Fig. 4b, SPM 8, Act. 2)

Continue to work with MAA to reduce tobacco use by pregnant women by implementing the Smoking Cessation benefit, and disseminating the provider reference card. (Fig. 4b, SPM 8, Act. 3, 4, 5)

Work with other MAA, OMCH, and other DOH programs to plan and execute the prenatal medical chart review project. The review will enable MCH to assess the general quality of prenatal care as well as look at HIV testing, and screening for substance use and violence. (Fig. 4b, SPM 8, Act. 6)

State Performance Measure 9: *Develop and implement a set of measurable indicators and a strategic plan to improve food security in the Washington MCH population, that is, absence of skipped meals or hunger due to lack of food.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective		33	66	80	100
Annual Indicator	26.7	33.3	53.3	63.5	70
Numerator	4	5	8		
Denominator	15	15	15		
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective					

Notes - 2002

THIS SPM HAS BEEN DISCONTINED FOR THE 2005-2009 NEEDS ASSESSMENT.

Benchmarks:
Due to space limitations, only Year 2 activities are described below.
Year 2 (October 2001-September 2002) Target: 66% / Cumulative Score: 53.6%
6.Maintained partnerships and disseminated baseline data to local health departments and other partners. (Score 3.3%)
·The MCH Nutrition Team was initially comprised of nutrition consultants in the sections of Maternal & Infant Health and Children with Special Health Care Needs. Participation on the food security issue was broadened to include representatives from the MCH Assessment Section, the Child & Adolescent Health Section, the DOH Office of Epidemiology, the Washington State WIC Program, and the Nutrition & Physical Activity Section of Community Wellness and Prevention.
·Baseline data on indicators of hunger and food security in Washington were pulled together from multiple sources for a grant proposal for Vitamin Settlement funds. Targeted distribution of this data has been not disseminated to local health departments. Local health jurisdictions are struggling to maintain current programs during these challenging economic times.

7.Convened a work group of local and state constituents related to MCH health promotion and who can represent Food Security and/or hunger issues. (Score 5.0%)
·A member of the MCH Nutrition Team was able attend monthly meetings of the Anti-Hunger and Nutrition Coalition.
8.Learned best practices for MCH populations from other state's public health interventions and literature review regarding promoting Food Security. (Score 6.6%)
oA review of best practices, existing data sources, and current literature was completed in the preparation of a grant proposal for Vitamin Settlement funds.
9. The workgroup will have identified and prioritized measurable indicators of Food Security to incorporate into an action plan. (Score 3.3%)
·The MCH Nutrition Team has identified food security questions to include in the state's Behavior Risk Factor Surveillance System (BRFSS), which will be included in the survey in 2003.
·Challenging economic times has also impacted the state health department. A state hiring freeze and reduction in staff has stifled the work of the MCH Nutrition Team. The lead staff on food security activities had to leave the department and the vacant nutrition consultant position could not be refilled. Federal funding to continue work on this performance measure is available into Year Three. A contract with the University of Washington has been negotiated to continue work on this performance measure to implement an action plan.
10. Researched and shared funding opportunities for state or locals, such as Food Stamp Education Project. (Score 3.3%)
Two components of the contract with the University of Washington are to specifically work with the Food Stamp Nutrition Education Program and the Summer Food Service Program.

Notes - 2003

Year 2 Activities Score: 9.9%
Cumulative Score: 63.5%

3. Completed Strategic Plan to promote and protect Food Security for MCH population. Plan will specify indicators, interventions, data collection, outcomes, and evaluation. (Score 3.3%)

§ While a formal strategic plan was not completed, MCH continued to work towards improving the nutritional status of the MCH population including:

· A contract was established with the University of Washington to guide the development of an MCH food security strategic plan.

· Data Collection and identifying Indicators:

· Stakeholder Input through the WA Anti-Hunger Nutrition Coalition (AHNC), closely affiliated with the Children's Alliance, is a non-profit statewide organization dedicated to reducing food insecurity.

· Key Findings and Themes for Intervention: WA in general, including the MCH population, has persistent food insecurity and hunger problems. There is a comparatively high prevalence of food insecurity, a significant gap between program eligibility and some food security program participation, lack of awareness on the part of the public and leaders and several groups at risk including minorities, non-English speaking, women (particularly single heads of households and younger mothers), youth in grades 6, 8, 10, and 12, poor/working poor and those living in rural counties. Based on data and stakeholder input analysis, five themes for potential objectives emerged: Access, Data/Reporting, Advocacy/Education, Organization/Coordination, and Improvements to WIC.

· Priority objectives identified by stakeholders, and estimated resources were discussed at the September 2003 CFH Nutrition Workgroup meeting.

4. Sought and obtained resource commitments for interventions and evaluation. (Score 6.6%)

· MCH Block Grant funds supported the work done through the University of Washington contract through September 2003, when the contract ended.
· Collaborative work continued in 2003 with the Basic Food Nutrition Education Program and the Summer Food Service Program at OSPI. Increased outreach to agencies serving the MCH population resulted in higher participation rates in 2003 in these two federally supported programs.
· The Community Wellness and Prevention section at the Washington Department of Health created a Nutrition & Physical Activity Section. The section released a Washington State Nutrition and Physical Activity Plan in June 2003 and includes a reduction of hunger and food insecurity as one of its nutrition objectives and priority recommendations. MCH will take advantage of this plan and work with CWP.
· The CFH Nutrition Workgroup has included food security and hunger in its top priorities for action.
· The MCH Managers and Director were presented with the prioritized objectives.
Additional MCH funding and staff commitments for Year 4 have not yet been established.

Notes - 2004

Year 4 (October 2003-September 2004)
Year 4 Score 70%

*Maintained partnerships and mutual commitments.
•MCH staff vacancies prevented an active role in maintaining partnerships. Fortunately, MCH partners have continued their support of activities to enhance food security in Washington State. Established mechanisms and contract work have also continued without a designated MCH staff lead.

*As resources are allowed, implement interventions according to Plan.
•Targeted MCH funding for food security activities was not available. Contracted activities and the work of MCH partners continued to support activities to enhance food security in Washington State.
*Collected data and evaluated indicators/outcomes and interventions.
•Existing sources of food security data continued to be collected. The data is available for a future evaluation of outcomes and interventions if and when an MCH staff person is available and assigned this work.

a. Last Year's Accomplishments

Implemented objectives and priorities as developed from the partnership meetings with OMCH, the Office of Epidemiology, the Washington State WIC Program, Nutrition and Physical Activity Section of CWP, the AHNC, and others.

Continued data analysis of the 2003 Behavior Risk Factor Surveillance System (BRFSS) and advocated for repeating the core set of six validated questions on hunger and food security for inclusion as state specific questions for the 2005 Behavior Risk Factor Surveillance System. (Fig. 4b, SPM 9, Act. 2, 4)

Local agencies responded to the needs in their communities by providing nutrition consultation to children with special needs and participating on community feeding teams, moving WIC services to the local health department to provide one-stop shopping, providing WIC information at community and tribal health fairs, providing language interpreters to WIC clients, and providing nutrition education to Hispanic women with diabetes.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Make nutrition a core element of childcare consultation.				X

2. Add food security questions to BFRSS and YRBS.				**X**
3. Contract with University of Washington to implement an MCH Food Security plan.				**X**
4. Monitor inclusion of state food security data indicators, and compile and distribute annual data report				**X**
5. Maintain state partnerships with food security constituents.				**X**
6. Enhance participation of organizations that serve the MCH population in the Food Stamp Nutrition Education Program and the Summer Food Service Program.			**X**	
7.				
8.				
9.				
10.				

b. Current Activities

Maintaining partnerships and mutual commitments to address hunger and food security in the Washington state MCH population, including support of the Healthy Mothers, Healthy Babies information and referral line. Through blended funding, HMHB is screening callers for nutrition and food security needs and giving referrals for Basic Food (1,627), WIC (21,414), nutrition information and services (83), and breastfeeding support (400).

Mobilizing resources to identify an OMCH food security lead.

Monitoring data sources and indicators of hunger and food security to evaluate trends.

c. Plan for the Coming Year

At this stage of the 5 year needs assessment, OMCH does not anticipate including this performance measure in Washington State MCH Block Grant applications and reports over the next 5 years. However, because nutrition is included in one of the 9 priorities, a performance measure may be added.

OMCH will continue to maintain partnerships and mutual commitments to address hunger and food security in the Washington MCH population, including ongoing support of the HMHB information and referral line with the addition of the family food line number anticipated for April 2005.

OMCH will mobilize resources to identify an MCH food security lead and monitor data sources and indicators of hunger and food security to evaluate trends.

State Performance Measure 10: *Increase statewide system capacity to promote health and safety in child care.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		25	50	70	85
Annual Indicator		5.0	35.0	64	74.5

Numerator		1	7		
Denominator		20	20		
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective					

Notes - 2002

THIS SPM HAS BEEN MODIFIED FOR THE 2005-2009 NEEDS ASSESSMENT TO: "Increase statewide system capacity to promote health, safety and school readiness of children birth to kindergarten entry." PLEASE SEE THE NEW SPM 8 FOR MORE DETAILS.

SHORTVERSION SP10
BENCHMARKS:
NOTE: YEARS 1,3,4,5 BENCHMARKS NOT INCLUDED DUE TO SPACE LIMITATIONS. ACTUAL SCORE 33%, BECAUSE OF PARTIALLY MET BENCHMARKS

Year 1 (October 2000-September 2001) Target: 25% (4 out of 18 benchmarks)
Year 1 Score: 5.5 %

Year 2 (October 2001-September 2002) Target 50% (9 out of 15 benchmarks) (CURRENT YEAR REPORTING ON)
Year 2 Activities Score: 18%
Score from Previous Year Activities Completed in Year 2: 5.5%
Score from Year 3-5 Activities Completed in Year 2: 9.5%
Cumulative Score: 33%
Benchmarks for Year 2:
1. Integrate internal activities in DOH and MCH as they relate to health and safety in child care, e.g. environmental health, oral health, health promotion (CHILD Profile), preventative health care (Bright Futures), parent education, immunizations, children with special health care needs, nutrition, early childhood, etc. (5%)
· Year 2: HCCW has identified integration with all of the above. Phasing in activities to move to the next level of formal integration and shared funding options, specific to CHILD Profile and Bright Futures. (Score 2.5%)
2. Partner with Washington State Child Care Resource & Referral Network to design GIS system to identify statewide child care capacity including sub-populations (5%)
· Year 2: Funding eliminated …other CC/ECH assessment activities identified as part of work with ECH partners; looking at health indicators with Head Start , Child Care and Early Childhood Education and Assistance Program (Score 3%)
3. Identify and implement phases of evaluation plan (5%)
· Year 2: Evaluation consultant hired and initial evaluation design phases identified. (Score 2.5%)
4. Determine long term training plan for child care health consultation including core training, NCAST, mental health, children with special needs, infants and toddlers, etc. (5%)
· Year 2: adjusted due to funding cuts however identified and completed additional modules for statewide CCHC training plan and discussions with HCCW team and partners re components of training plan, feasibility of developing core competencies and integration into evaluation work (Score 5%)
5. Build collaborations with child care and insurance providers, MAA, HCA access to health insurance and a medical home for children in child care (5%)
· Year 2: currently working with WaAAP, EPSDT Improvement Grant, MAA, Medical Home Project, Bright Futures, Head Start State Collaboration Project, OSPI-STEPS program, and ECEAP to addresss this issue. (Score 5%)

Notes - 2003

Year 3 (October 2002-September 2003) (CURRENT YEAR REPORTING ON)
Year 3 Target: Target 65% (13 out of 20 benchmarks)
Score from Previous Year Activities Completed in Year 3: 12%
Score from Year 4-5 Activities Completed in Year 2: 1%
Year 3 Score:13.5
Cumulative Score: 59.5%
Benchmarks for Year 3:
1. Develop core competencies for child care health consultation (5%)
· Year 2: None
· Year 3: Developed core competencies w/ stakeholders and integrated into evaluation process and tools for CCHC. (Score 5%)
2. Integrate scientific knowledge into policy and practice as it relates to health and safety in child care (e.g. through training plan, core competencies, etc.) (5%)
· Year 2: Final phases of 'orientation' packet and 'resource kit' for CCHC's ; ongoing activity as we modify trainings, resources, and implement evaluation work (Score 4 %)
· Year 3: Completed CCHC Resource Kit and CD integrating all training modules revised in new template format for consistency. Distributed to all LHJs statewide. Additionally, developed new modules to address Emergency Preparedness and National Health and Safety Standards, "Caring for Our Children" (Score 1%)
3. Identify integration opportunities regarding Immunization WAC for child care and the scope of local child care health consultation (5%)
· Year 2: negotiation with DSHS/Division of Child Care and Early Learning (DCCEL) re: integration of immunization WAC into child care WAC (Score 2.5%)
· Year 3: Creating pilot project for CCHCs to improve immunization status in child care by utilizing the CHILD Profile Immunization Registry as a result of AG opinion allowing CCHC access to the Registry. Additionally partnering with DCCEL licensors to assist child care providers to meet the CC Immunization WAC. (Score 2.5%)
4. Provide resources for outreach, education, regarding children's access to health insurance and a medical home (5%)
· Year 2: working with Wa AAP and EPSDT Improvement Team and grant work. (Score 1%)
· Year 3: Partnered with WaAAP to facilitate 2 multidisciplinary focus groups, one on each side of the state, to promote medical providers role in health and safety in child care. HCCW provided each physician with copy of "Pediatricians Role in Child Care" (Score 2%)

5. Communicate the work of HCCW through development of brochures, web-page, annual report, and fact sheets designed for various audiences
Year 3: Developed new HCCW Brochure and in created new web-page in partnership with Washington State Child Care Resource & Referral Network (Score 3%)

Notes - 2004

Year 4 Target: Target 85% (17 out of 20 benchmarks, worth 5% each)
Year 4 Score: 74.5%

*Pursue long term funding strategies, both public and private, for health and safety in child care.
•The Healthy Child Care Washington Advisory Committee meets monthly to discuss public and private funding strategies.
*Collaborate with internal and external stakeholders to create comparison of national child care standards with Washington standards for child care and early childhood
oYear 2: First phase completed 2001 with Comparison of National CC Standards. Second phase under way now to compare across ECH programs including CC, HS, ECEAP, NACCRA, and newly revised National Child Care Standards – to be complete 2003. (Score 2.5%)
oYear 3: Mapping Project completed (Score 1%)
oThe national child care standards were used as references and citations when contributing to the guidebook for using Washington State child care center WACs.

*Determine numeric ‘benchmarks’ for HCCW program outcomes after collection of first year evaluation data (e.g. 5% of CCHC’s demonstrate CCHC core competences; 2.5% of CC providers receiving CCHC report changes in practice due to consultation)
•The Healthy Child Care Washington outcome-based evaluation created two new data collection forms for child care health consultants to utilize when reporting. Initial usage of the forms began in October 2003 and statewide usage of both forms was launched in July of 2004. In addition, a web-based data collection system (Healthy Child Care Washington Data Collection–HCCWDC) was created for child care health consultants to input their data. Initial usage of HCCWDC began in October 2003 and statewide utilization began in July of 2004 as well.
•Evaluation results showed (among other things) the number of encounters child care health consultants reported, the length of the encounters, which topics were discussed and how many children and child care providers were impacted. In addition, actual changes in child care practice were measured in terms of knowledge, awareness, behavior, communication and health. An interim report was published in January of 2005. The final report, as well as an Executive Summary, was published in June of 2004.

a. Last Year's Accomplishments

Healthy Child Care Washington (HCCW) maintained a Child Care Health Consultant (CCHC) in each LHJ and focused on infrastructure and population-based activities. HCCW statewide training plan identified core competencies for CCHCs based on best practices and quality improvements recommended from the evaluation plan. (Fig. 4b, SPM 10, Act. 1, 2, 4)

A state-level CCHC provided training, technical assistance, and consultation to each LHJ through regional trainings. A one-day seminar (June 2004) brought together CCHCs and early childhood experts. (Fig. 4b, SPM 10, Act. 2)

HCCW initiated its mandated transition into the Early Childhood Comprehensive Systems (ECCS) grant by making staffing changes. One staff member is now dedicated to the ECCS grant, while the other has taken over the Child Care Health Consultation work with HCCW. (Fig. 4b, SPM 10, Act. 3)

HCCW focused efforts on statewide implementation of its evaluation plan for the CCHC system, which includes data collection in the new web-based application to track outputs, indicators, and outcomes as identified in the HCCW logic model. One of two new data collection tools was launched statewide in October 2003 and the other was launched in July 2004. The evaluation data collection tools are designed to provide continuous quality improvement based on the following four outcomes: increased institutionalized systems; increased use of skills and standards for CCHCs; increased direct service providers' use of practices that promote a child's social, emotional, and physical, health, and cognitive skills; and improved communication between child care providers and parents about child care quality and developmental or behavioral challenges. The web-based HCCW data collection system is also in use statewide. (Fig. 4b, SPM 10, Act. 4)

The CSHCN Program contracted with the Center for Children with Special Needs at Children's Hospital and Regional Medical Center to survey those who provide education to child care providers to determine their training needs. The survey results revealed a lack of knowledge on communicating with parents regarding their children's special needs. Materials were developed to share with child care providers.

The Grant County Immunization Registry pilot project began in June 2004. The pilot was designed to determine the level of interest and feasibility of implementing statewide CCHC access to the CHILD Profile Immunization Registry and CCHC's support of child care agencies immunization verification and documentation. (Fig. 4b, SPM 10, Act. 5)

Child care consultation is delivered by public health nurses in many LHJs. Some examples of activities include providing information and materials on developmental milestones; training on the unique needs of children with chronic health conditions, disaster preparedness, medical

management, behavior and age appropriate discipline, brain development, allergies, and food safety; and providing oral health teaching materials and dental supplies.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Contract with LHJs to support child care health consultation.				X
2. Manage contracts that support the work of LHJs by providing training and technical assistance to Child Care Health Consultants.				X
3. Promote partnerships and collaboration with childcare stakeholders including the Division of Child Care and Early Learning, Early Head Start/Head Start, OSPI, and others to promote health and safety in children care.				X
4. Continue the statewide, outcome-based evaluation of Health Child Care Washington.				X
5. Develop a statewide CHILD Profile Immunization Registry Access Expansion plan that will allow Child Care Health Consultants to access the registry to address immunization issues of children in schools, child care centers, and homes.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

HCCW continues to support a Child Care Health Consultant in each LHJ and to focus on infrastructure and population-based activities. HCCW continues to utilize its evaluation plan results to modify and enhance the system and to identify core competencies for a statewide training plan for CCHCs based on best practices and quality improvements. (Fig. 4b, SPM 10, Act. 1, 2, 4)

HCCW's state-level Child Care Health Consultant continues to provide training, technical assistance, and consultation to each LHJ through regional meetings. New or modified training modules include "Oral Health", "Food Safety", and "Promoting Healthy Lifestyles" ("Increasing Physical Activity", "Decreasing Screen Time", and "Providing Nutritious Snacks in Early Care Settings"). HCCW continues to research emerging best practices for various health issues. HCCW sponsored a 3-day, statewide health symposium, in collaboration with Head Start & ECEAP, where a variety of health-related topics were offered to a diverse audience from multiple states. (Fig. 4b, SPM 10, Act. 2)

HCCW continues efforts to integrate with the ECCS grant, linking the HCCA Blueprint for Action and ECCS's five components (Medical Home, Social Emotional and Mental Health, Child Care and Early Learning, Parenting Education, and Family Support). ECCS completed strategic and evaluation plans to clarify the public health role in early childhood. The HCCW and ECCS Advisory Committees are working to merge. ECCS is working on plans to create and distribute a document detailing DOH's role in early childhood and continues to strengthen existing partnerships for building a comprehensive early childhood system across state agencies. ECCS implementation begins September 2005. (Fig. 4b, SPM 10, Act. 3)

HCCW focused efforts on full statewide implementation of the evaluation plan and continues to modify the web-based application to be more efficient and user-friendly. HCCW focuses efforts on

training CCHCs on the proper use of the data collection system in order to reduce duplication and collect clean data. (Fig. 4b, SPM 10, Act. 4)

The Immunization Registry pilot, launched by HCCW, Head Start, CHILD Profile and other partners, concluded this year. HCCW and CHILD Profile are evaluating the success of the project, determining the lessons learned, and making recommendations for implementing the expansion of registry access to CCHC's statewide so that CCHC's can address immunization status issues in out-of-home and in-home child cares. (Fig. 4b, SPM 10, Act. 5)

This year, the Children with Special Health Care Needs Program, via a contract with Children's Hospital and Regional Medical Center, will distribute and evaluate a training for child care providers entitled "Communicating with Parents."

c. Plan for the Coming Year

OMCH has revised and expanded this performance measure for Washington State's MCH Block Grant applications and reports for the next 5 years.

HCCW will continue to support a CCHC in each LHJ and to focus on infrastructure and population-based activities. HCCW will use its evaluation plan results to modify and enhance the system and to identify core competencies for a statewide training plan for CCHCs based on best practices and quality improvements recommended from the evaluation plan. (Fig. 4b, SPM 10, Act. 1, 2, 4)

HCCW's state-level Child Care Health Consultant will continue to provide training, technical assistance, and consultation to each LHJ through regional meetings. Due to anticipated funding decreases, regional on-site consultation and technical assistance (instead of one-on-one on-site visits) will be encouraged for efficiency. HCCW plans to conduct additional trainings on "Increasing Physical Activity" and "Decreasing Screen Time" and will continue to research emerging best practices for various health issues. (Fig. 4b, SPM 10, Act. 2)

HCCW will continue efforts to integrate with the Early Childhood Comprehensive Systems grant. The HCCW and ECCS Advisory Committees plan to merge with the Head Start--State Collaboration Advisory Committee and the Foundation for Early Learning (BUILD Initiative) into a broader state advisory committee. ECCS plans to identify and create a document for distribution, which details the Department of Health's role in early childhood. ECCS will continue to strengthen existing partnerships for early childhood work through implementation of the statewide early childhood plan called "Kids Matter: Improving Outcomes for Children in WA State." The work of ECCS will continue to aim to influence statewide efforts to build a comprehensive early childhood system across all state agencies. (Fig. 4b, SPM 10, Act. 3)

HCCW, in collaboration with CHILD Profile, anticipates beginning implementation of the Statewide CCHC Immunization Registry Access Expansion plan. The expansion plan will provide CCHC's with access to the CHILD Profile Immunization Registry in order to address immunization status issues in schools, and in out-of-home and in-home child cares. (Fig. 4b, SPM 10, Act. 5)

E. OTHER PROGRAM ACTIVITIES

Bright Futures. The OMCH has increased its capacity to expand state and local efforts to implement Bright Futures as a best practice for child and adolescent health care. OMCH has: Contracted with the UW to do statewide awareness activities; received additional federal funding to promote the use of Bright Futures in Head Start, state preschool, and child care settings; and worked with the national Family Voices organization to implement "Family Matters: Using Bright Futures to Promote Health and Wellness for Children with Disabilities." This is a three-year grant funded by the CDC in which Washington State is one of the pilot sites.

EPSDT. MAA developed a series of charting inserts for health care providers to use in documenting EPSDT exams. The purpose of the chart insert was to improve documentation and completion of EPSDT exams. This need was identified through the yearly review of the MAA Healthy Options Plans. The OMCH provided input into the content and format of the insert forms as well as sites to pilot the forms. The development of this standardized charting insert enabled CHILD Profile to create a Health and Development card for parents to use in keeping track of EPSDT/Well-Child Checkup information.

SIDS Reduction Project with African Americans Project. MIH contracts with the Tacoma-Pierce County Health Department to promote risk reduction for SIDS in the African American Medicaid-served community. Local outreach and education will be provided to First Steps providers, child care, churches, and African American leaders and community members.
First Steps Redesign Project. The Medical Assistance Administration in DSHS and the Department of Health have worked in coordination with providers to redesign the First Steps Program effective October 1, 2003. The revisions are in response to budget concerns and a major review of the service delivery model. Goals of redesign were to improve the quality of services; contain expenditure growth; and tie intensity of services to client need. The redesign included development of Core Services to include client screening, basic health messages, basic referrals/linkages and minimum level of intervention for identified risk factors. Over the first year of implementation ongoing evaluation of revisions will occur, a standardized documentation system will be developed, monitoring and training plans will be developed, and group activities will be piloted in three sites across the state.
First Steps Outreach Project to Native Americans. MIH is contracting with the Seattle-King County LHJ to assist the state program in providing outreach to tribes in an effort to increase utilization of First Steps among Native Americans. Recommendations from tribal representatives will be incorporated into the First Steps redesign which may include special staffing considerations for rural and tribal communities.

Drug-Endangered Children. OMCH staffs are working with a local coalition, including representatives from law enforcement agencies, on possible ways to provide legal protection for drug-endangered children.

Living Room Forums. The Genetics Services Section contracted with Publicis Dialogue to conduct 15 informal forums with members of the public to gather qualitative data and opinions about three topics related to genetics. The topics were newborn screening, equity of genetics services, and genetic discrimination. The results of the forums will be used to inform the state genetics plan. The Genetic Services Section is now in the process of analyzing the data.

Prenatal Care Collaboration. Maternal and Infant Health, in collaboration with the Tobacco Prevention and Control Program, contracted with Insight Policy Research to conduct focus groups and key informant interviews with OB providers in Washington. The purpose of this project was to determine effective strategies for influencing and improving screening and intervention for prenatal substance abuse (including tobacco) and violence. A total of 36 providers participated in this research that was completed in December 2003. Physicians were most interested in practical, concise information for themselves and their office staff. MIH will use this information to help guide strategies to disseminate best practice issues to OB providers.

OMCH Publications. In 2003, the OMCH distributed a variety of publications addressing issues of importance to the MCH population. These documents were made available in print and on the OMCH internet site to a number of public health stakeholders including state and federal agencies, public health professionals and associations, parent and family organizations, and the public.

Below is a list of OMCH publications for 2004:
•MCH Data Report
•Perinatal Indicators Report
•Healthy Child Care Washington Evaluation Report

F. TECHNICAL ASSISTANCE

1. General Systems Capacity Issues

a. CSHCN Program
OMCH wants to provide training at each of four CSHCN regional meetings to local LHJ providers on how to interview families of children with special health care needs in a way that is culturally competent. One of the benefits of this training would be to improve the quality of data collected from families by local CSHCN providers to include elements of ethnicity, education, and economic levels so information can be used in program development. We need a trainer who could teach culturally competent interviewing strategies related to children with special health care needs and their families.

b. Cultural Competence
The U.S. Department of Health and Human Services' Office of Minority Health issued standards for Culturally and Linguistically Appropriate Services (CLAS). These standards and the implementation compendium are excellent guidelines for health provider agencies to use to better address the cultural and linguistic needs of the populations served. OMCH (Health Disparities Task Force) is requesting assistance in acquiring training on the implementation of these standards for state and local agency staff.

c. Performance Measure Targets
OMCH seeks technical assistance for training on setting targets for performance measures. The audience for this training would be both assessment and program staff. The training would help us develop the skills to develop realistic targets for the national and state performance measures for the Maternal and Child Health Block Grant.

d. Integration
OMCH needs expert facilitation to focus on intra-agency collaboration to improve the health services system for children and families. OMCH/DOH needs to integrate programs within the agency in preparation for cross-agency collaboration. Families often need services from a variety of state programs, agencies and community organizations, but find the services difficult to locate, navigate, and differentiate. OMCH/DOH is collaborating with multiple state and local agencies and organizations on four goals to make the health system work better for families: a common enrollment/application process for easy entry, care coordination to assist families in defining and meeting needs, cross-agency data linkages for program planning, and opportunities for blended funding to maximize impacts.

e. Fragile X Education
There have been many advances in the area of testing for Fragile X and many are even considering targeted newborn screening. Therefore, an educational conference for genetic service providers is being planned for 2004/2005. Technical assistance funds are being sought to bring a nationally known speaker for this event.

f. Adolescent Health
The OMCH needs assistance to collaborate with other state and territorial adolescent health coordinators in order to improve access to national resources and experts on adolescent health. This will improve program development and expertise at the state and territorial level. The MCHB would provide support for travel and per diem to attend an annual meeting and funding or assistance in setting up bridge-lines for conference calls between regions.

2. State Performance Measure Issues

a. Nutrition
This request relates to priority 1 for improving the nutrition status among the MCH population. Expert advice is necessary to review the strategic plan and food security activities developed to address nutrition status. A sound review of the strategic plan and activities will aid the MCH Nutrition Team in mobilizing and enlisting partner support to address hunger and food security in the MCH population.

b. Domestic Violence Prevention
PPADV committee members have requested a presentation on the new DV and Public Health Booklet published by the Family Violence Prevention Fund and written by Linda Chamberlain. Dr. Chamberlain

agrees to present for half a day to the PPADV on this topic. MCH staff would like to set up consultation for state and local MCH staff regarding: PPADV curriculum revisions by SeaKing and State Injury Prevention, evaluation of DV training and developing measures for the effects of child witnessing of domestic violence. Dr. Chamberlain comes from Alaska.

c. Healthy Relationships
The Healthy Relationships Project would like some technical assistance from other MCH state youth projects. The project staff is exploring options within four different states. The purpose of the TA visit would be to: Review current HR proposals and results from external groups; develop a work plan that would provide direction for activities; and provide guidance. The person selected would be a person who has a project within their state that focuses on prevention of intimate partner violence. This speaker would be invited to present at a MCH Teams meeting.

3. National Performance Measure Issues

a. Decision-Making and Comprehensive Care for Children with Special Health Care Needs
This request relates to NPM 2 and 3 in the areas of decision-making and comprehensive care for children with special health care needs. On-going leadership and skills development and cultural competence training are needed to ensure that families with children with special health care needs can partner in decision-making, serve as mentors, and participate in comprehensive systems development. OMCH would like to bring a consultant from the National Center for Cultural Competence to provide training related to family leadership for children with special health care needs and parent consultants.

V. BUDGET NARRATIVE

A. EXPENDITURES

The State of Washington uses the Agency Financial Reporting System (AFRS) as its accounting system. Throughout the reporting year, direct program expenditure data is entered and tracked by the MCH Budget and Contracts Manager as well as program managers and fiscal coordinators. Aggregated data from this report are adjusted to add overhead costs, which have been entered through the agency allocation system (submitted to and approved by DHHS, Region X). The data from both these sources form the basis for the total expenditure data for the year.

The total expenditure data is entered onto spreadsheets by program. This data is apportioned across reporting forms 3, 4, and 5 according to percentages determined by program managers, staff, and local health jurisdictions. Expenditure data is then apportioned to the 30%-30% requirements, and the 10% Administration requirement. This same expenditure data is also apportioned according to percentages designated for Populations Served (Form 4) and Levels of the Pyramid (Form 5). In this way, OMCH is able to demonstrate relationships among expenditures and requirements, Populations Served, and Levels of the Pyramid.

The results of the above calculations are then entered on additional spreadsheets, which contain historical data. From these latter spreadsheets come the variances. Significant variances are analyzed and accounted for. The information is used in building the budget for the coming federal fiscal year.

B. BUDGET

Washington State's biennium runs from July 1 of odd-numbered years through June 30, two years following. The Agency Financial Reporting System (AFRS), which contains past, present, and future time periods, does not allow for data input into a succeeding biennium until the new biennium has commenced.

Previously, Washington State DOH's policy was to recognize federal grant allotments on the first day of the grant budget period, or upon receipt of the Notice of Grant Award, whichever was later.

For the biennium 03-05, Washington State implemented a new policy. Federal grant allotments were estimated for the whole biennium and entered in AFRS. Allotments were adjusted to reflect actual awards. This policy will continue through the 05-07 biennium.

The FY06 MCHBG application reflects the most recent award amount; consequently, FY05 will be used. For FFY06, actual expenditure data for FFY04 from Forms 3, 4 and 5 has been used in the projections. OMCH adjusts this baseline information for known or anticipated funding or category allocations as well as economic conditions.

While it is expected that the MCH program will achieve its maintenance of effort amount and 75% match, declining funding sources has meant that MCH does not anticipate being able to overmatch its federal allocation. Washington State's Maintenance of Effort is $7,573,626. For FY06, match will be achieved using state funding as well as Health Services Account (HSA) funding for the Immunization Program.

Recent legislation permitting solicitation of funds indicates that in the future, there will be funds available for MCH activities from corporate partners. This activity is still in its infancy; therefore, it is impossible to estimate budget amounts at this time. Should this occur in any significant manner, OMCH expects variances when it reports for FY06.

Other federal sources, including Title XIX; a number of HRSA and CDC grants; and DSHS Interagency Agreements, complement Washington State's total effort. Additionally HSA dollars and local funds support to activities addressing the MCH population.

Through contracts providing funding to local health jurisdictions (LHJ"s), OMCH ensures that the minimum

30%-30% requirement is met. In order to receive funding the LHJ's must submit a plan designating at least 30% to CSHCN and Preventive and primary care for children. The plan ties related activities to CSHCN and Primary and Preventive care for children, Populations Served and the Pyramid. The LHJ's report their expenditure activity by Populations Served and the Pyramid. At the state level, this data forms the basis for allocation of funds across programs. Using actual data from FY04, OMCH projects that 52.43% of its budget will be expended on Preventive and primary care for children; and 31.34% will be expended for Children with Special Health Care Needs. Finally, OMCH is budgeting 6.34% for Title V Administrative costs.

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.